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# *the* Health *of* Washington Women

Findings from the  
Washington Women's Health Assessment

Washington Women's Education Foundation

August 1997

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# About This Report

*The Health of Washington Women* is the first report of its kind in the nation to address women's health status and needs on a statewide basis.

State and national health system reform efforts during the early 1990s revealed the need for this report. As Washington's health services delivery system changed rapidly in response to new public policies and market forces, it became apparent that state policy makers needed a single information source on women's health that would analyze and present information from many different sources and forms. In July 1996, the Washington Women's Education Foundation responded to this need by assembling a group of health care professionals, academicians, policy makers, and advocates to develop a baseline report measuring Washington women's health status and access.

As we embarked on this work, we embraced a view of women's health that accounts for the complex interactions among the social, economic, political, and environmental factors that affect women's lives. For Washington State's health care system to respond appropriately and effectively to women's needs, it must recognize the material conditions in which they live — their family structure, incomes, housing — as well as the critical public health issues of disease prevention and treatment, nutrition, environmental health, and access to screening services. The system must acknowledge the changing needs of women across the lifespan and reflect the value of each woman.

We have made every effort to reflect this broad approach to assessing women's health. We do not, however, present this report as a truly comprehensive document. We have based our analysis on the best and most timely information available, but it was not within the scope of this project to collect new, or primary data. It is our hope that this report serve as the first step to fully assessing Washington State women's health status and concerns and establishing systems that will capture the entire scope of women's health care needs. It is our hope that Washington women will be given a commitment of resources toward assuring the best health care standards possible.



# Executive Summary

This study set out to report on the health and well-being of women who differ from each other in age, race, ethnicity, sexuality, income, education, and nearly every other characteristic. For by “Washington women,” we refer to women who experience itinerant lives on wheat and fruit farms, who feel the stresses of dense urban communities, and the geographic isolation of rural ones.

The women of Washington were born on the Olympic Peninsula, in downtown Seattle, on the Reservation, in Mexico, in Viet Nam. They are professional women, grandmothers, homemakers, high school and college students, and women struggling to support themselves and their families.

The broad issue of health, however, draws these women together in ways that we can study. For all these women want to stay healthy. They want to live as free as possible from disease and injury so they can perform their roles in their families and communities and at work. They want to have healthy pregnancies and babies. And when they are sick, and to ensure that they stay well, they need access to health care providers.

In many cases, we can determine whether women are meeting these hopes and needs by analyzing state and national health data and by talking with selected groups of women about their health and well-being. In this report, we summarize what these sources tell us about Washington women and what Washington women tell us about themselves.

## What the Data Say

For the most part, the data presented in this report show that the nearly 2.8 million women who live in Washington State are living longer lives, are making many positive decisions about their health, and experience, on average, a better standard of living than do U.S. women as a whole.

But the over-all picture is complex and mixed. Some women, particularly those 75 years and older, are surprisingly poor. Others continue to engage in behaviors that pose extreme risks to their health. A considerable share of women say they are not able to access health care, and in some

cases, this problem has deadly consequences. There is also a disturbing consistency to our findings about tobacco use among Washington women and the consequent health burden. The share of pregnant women who smoke, for example, is higher than state and national targets. Death rates among Washington women from two tobacco-related causes of death — lung cancer and chronic obstructive pulmonary disease — have risen dramatically. And Washington women exceed the national target for death rates from oral-pharynx cancer, which is also tobacco-related.

In this study, we have organized our analysis of national and state data in four chapters: Sociodemographics; Health Status and Lifestyle Choices; Health Care Access; and Health Status Indicators. The following are the key findings from each chapter.

**Sociodemographics** — The first chapter explores the age, race, ethnicity, income, family composition, and type of residence of Washington women — all conditions that influence health. We found the following:

- Washington women are getting older, and in common with women in the U.S. as a whole, they live longer than men. Their median age in 1995 was 35.1 years.
- Nearly 9 or every 10 Washington women are white, and nearly 7 of every 10 live in what the Census Bureau defines as urban areas. In 1990, women headed about 9% of Washington households.
- Washington women who were employed full-time and year-round in 1990 earned about \$21,000, about 34% less than Washington men.
- About 11.3% of Washington women ages 16 to 64 live below the federal poverty level. More than a third of families headed by women who are younger than 65 live in poverty. And Washington women who are older than 75 experience a surprisingly high poverty rate of 15.8%.

**Health Status and Lifestyle Choices** -The second chapter recounts Washington women's responses to questions, in national surveys, about their mental and physical well-being and behaviors that may affect their health. Their responses show that:



- Washington women in 1994 reported more days of poor mental and physical health than did men.
- In common with national trends, Washington women are less likely than men to experience a sedentary lifestyle and more likely to engage in regular physical activity.
- Washington women are less likely than men to smoke and are more likely to eat health-sustaining fruits and vegetables. But about a fourth of Washington women are overweight.
- Washington women are less likely than men to have had a blood test for AIDS.

**Health Care Access** — The third chapter examines what share of Washington women have a regular source of health care and their use of preventive health care services. Our key findings are:

- About 10% of Washington women did not participate in a health insurance plan in 1994, and 12% reported that they were unable to see a doctor because of cost.
- Women who were 65 and older, those with less than a high school education, and those with an annual income of less than \$15,000 were less likely to use mammography and have regular Pap smears.
- Women whose deliveries were financed by the Medicaid program were more likely to report that the births were unintended.
- Abortion rates have fallen for all Washington women, and particularly for teenagers, since 1980.
- Nearly 83% of Washington women now receive timely (beginning in the first trimester) prenatal care.

**Health Status Indicators** — The fourth chapter focuses on four aspects of Washington women's lives: domestic violence; sexually-transmitted diseases; birth-related indicators; and mortality patterns. This is what we found:

- **Reports of domestic violence are rising in Washington, as evidenced** by an increase in both the rate of petitions asking for protection from violence or harassment and the arrest rates for domestic violence.

- Rates of infection for pelvic inflammatory disease, gonorrhea and syphilis fell for Washington women during the early 1990s and were lower than national targets.
- Nearly 27% of Washington births were to single women in 1995, twice the 1980 rate.
- The teenage birth rate in Washington rose by about 25% from 1980 to 1995.
- The life expectancy of Washington women was 79.7 years in 1995, compared with 74.1 years for men. The leading causes of death for all Washington women during 1993 to 1995 were heart disease, cancer, and chronic obstructive pulmonary disease (COPD).
- Death rates from two tobacco-related causes of death, lung cancer and COPD, are rising dramatically among Washington women.
- The cervical cancer death rate among Washington women has never met the national target in *Healthy People 2000*, the inventory of health objectives for the nation, and it achieved the Washington State target only once in 16 years. The age distribution of Washington women who are dying from cervical cancer reveals that postmenopausal women may not be accessing regular Pap smear tests.

## What Women Say About Their Health

No numbers can entirely capture the essence of what being “healthy” means to diverse groups of women. To collect women’s own accounts about how they see issues of health and access to health care, the Washington Women’s Education Foundation from December 1996 through April 1997 facilitated eight focus groups: African American Women in Pierce County; Women of the Colville Indian Tribe in Okanogan County; DSHS clients in Pacific County; Ethnic Chinese Women in King County; Hispanic Women in Toppenish, Yakima County; Homeless Women living in Seattle shelters; Lesbians in King County; and Older Women in King County.

These discussions centered on what these groups of women do when they are sick. But they addressed much broader issues: different cultures’ understanding of wellness; how the health services delivery system responds to women of different ages, sexuality, race and ethnicity; and the roles that



women's families and communities play in protecting and promoting their health. In the course of the focus groups, women discussed whether they are usually able to access and pay for health care, whether their health care providers consider all the factors — nutrition, diet, exercise, and other behaviors — that affect their health, and whether these providers respect women's traditions and beliefs.

Though the women participating in the focus groups represented vastly different lifestyles, ages, cultures, and socioeconomic status, several working themes emerged from the meetings:

- When sick, Washington women generally rely on treating themselves first, unless symptoms are very severe. They often use home remedies, naturopathic remedies, family support, rest and relaxation to manage sickness.
- Women report a broad range of issues they feel are hurting the health and well-being of their communities, including safety concerns, economic pressures, substance abuse, chronic illness and disease, mental illness, and lack of health information and education.
- Many women report that income status affects the quality of care they receive and whether their providers treat them with respect.
- Many women noted the strengths of their immediate community to care for itself and its members, particularly in time of crisis.
- Younger women appear to be more comfortable seeking out mental health services than are middle-age and older women.

Many women report that their health care providers are not mindful of a women's life context — providing services and care that are sensitive to race, ethnicity, culture, sexuality, and age.

- Many women report favorable experiences with community-based clinics, where they feel providers understand their needs and make them welcome.
- Most women interviewed suggest that the most comprehensive and appropriate care has been available to them during pregnancy.

(Direct quotes from all eight focus groups appear throughout the pages of this report, and a full report of the focus groups is available from WWEF.)



## Policy Recommendations

Together, the quantitative and qualitative information presented in this report identify five major gaps in supporting the health of Washington women. These gaps may be addressed through policies that would have long-term health and financial benefits for all Washington residents. In this section, we summarize these needs and present recommendations for action.

### 1. Access to Primary Care

Our health services delivery system must focus on ensuring access to primary care services such as health promotion and maintenance and disease prevention through a woman's lifetime. Although both public and private health insurance generally cover the costs of accessing life-saving screening measures such as mammograms and Pap smears, gaps in coverage remain. Medicare covers mammograms only every two years. Many private health plans require prohibitive copayments for preventive services. And many older women and low-income women are not obtaining adequate preventive care, resulting in hundreds of preventable deaths each year in Washington, particularly in the area of breast cancer and cervical cancer. The need for regular Pap smears is compounded by the relatively high frequency of inaccurate laboratory test results, particularly false negative Pap smears. Because early detection of cervical cancer is key, if a woman does not receive another routine Pap smear in a timely fashion, her risk of developing invasive cervical cancer increases substantially.

**Recommendation:** Require 100% coverage of annual Pap smears, mammograms and breast cancer exams by health plans in Washington. Expand education for women and their health care providers on the risks, diagnosis, and treatment of breast and cervical cancer throughout the life span, particularly later in life. Encourage meaningful participation and funding for the Breast and Cervical Health Program, a public health-directed outreach effort focusing on low-income women ages 40 and older. Continue to expand access to coverage through Medicaid and the state-subsidized Basic Health Plan.

## 2. **Smoking**

Smoking is the single most preventable cause of premature deaths among Washington women, accounting for 1 of every 6 deaths overall in the state. The incidence of lung cancer increased among Washington women sixfold from 1960 to 1980 — a far steeper increase than the incidence for men. Tobacco use is responsible for 80% of deaths from COPD. Research is also beginning to indicate links between smoking and development of cervical and breast cancer. About 1 of every 6 pregnant women smokes, putting babies at risk for low birthweight, premature deliveries, spontaneous abortion, stillbirth, and long-term developmental and behavioral effects from exposure to tobacco.

**Recommendation:** The U.S. Food and Drug Administration (FDA) has approved numerous programs and products that fight tobacco addiction; access to these should be available within every public and private health plan formulary, without financial barriers, and providers should work with patients to promote tobacco cessation. As more than 80% of smokers become addicted before they reach 18, policy makers should adopt legislation that keeps tobacco out of the hands of minors by prohibiting mail order sales and samples, by prohibiting fixed outdoor tobacco advertising or promotion, by applying cigarette retailer licensure requirements, by authorizing the Liquor Control Board to impose penalties for violation of tobacco laws, by providing local governments with more power to control minors' access to tobacco, and by directing more resources to support the state Department of Health's youth tobacco prevention account.

## 3. **Domestic Violence Against Women**

Domestic violence is associated with nearly half of all physical assaults and more than a fourth of all homicides in Washington. As many as 30% of all U.S. women may experience physical or sexual abuse during their lifetimes. And domestic violence is not confined to women; some 75% of battered women indicate that their children are battered as well. The data in this report show clearly that peti-

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tions for protective orders from domestic violence or harassment, as well as reports and arrests for domestic violence incidents, have been on the increase as well. But it is difficult to determine whether domestic violence itself is on the rise, or whether recent statistics reflect greater community awareness and increased reporting.

**Recommendation:** Prevention should focus on three key areas. First, provide training and screening protocols for health care providers and facilities. The Washington State Medical Association is a national leader in developing physicians' roles in assisting victims of domestic violence; such programs should be encouraged and expanded to include non-physician primary care providers. Health care facilities, particularly hospital emergency rooms, should develop and implement adequate protocols and resources to identify, treat, educate, and refer victims of domestic violence. Second, provide treatment for batterers and persons at risk of becoming batterers through such efforts as anger management and identifying root causes of behavior. And third, provide treatment, support, and assistance for victims or potential victims of domestic violence. Ensure that appropriate resources are always readily available for adequate interventions.

#### 4. **Reproductive Health**

Of the nearly 400,000 Washington women who live within 200% of the federal poverty level, only 30% to 40% have access to contraceptive services through state and federally funded family planning programs. About 55% of pregnancies in Washington State in 1995 were unintended; among low-income women receiving Medicaid, 62% of births were unintended. Family planning is basic preventive health care for women; it is also cost-effective. State figures show that contraceptive services in public clinics cost about \$150 per client, compared with about \$4,750 per client for publicly financed prenatal care, labor, and delivery costs. (Washington taxpayers paid for 41% of births in the state in 1996.)



**Recommendation:** All health plans in Washington should cover the full range of FDA-approved contraceptive methods; a recent survey showed that only 20% of plans now achieve this standard. State policy should increase funding for subsidized contraceptive services for low-income uninsured women. Access to reproductive health services should be comprehensive, culturally appropriate, and include both medical services and related counseling and patient education. Services should be provided in a variety of settings, including health plans, community clinics, public health departments and districts, and school-based clinics. Schools should improve and expand age-appropriate comprehensive sexuality education. And Washington women should have access to a 24-hour statewide clearinghouse for information on family planning information and services,

## 5. **Data Needs**

We need more and better data on women's health to gain a complete picture of the health of Washington women. We must also improve access to and education about the data that are collected by public agencies and/or private entities. Several health plans and organizations have already recognized this need for more thorough data collection, and they are making strides in developing and implementing a closed, proprietary system for the collection and sharing of insurance data (through the Community Health Information Technology Alliance). To the extent that this information remains private, the potential benefit to the public is drastically limited.

**Recommendation:** Develop and implement a "one stop shop" for health care data — a comprehensive, integrated health care data collection and reporting system based on all patient contacts in Washington. This endeavor would require cooperation and coordination among public health entities, state agencies, health plans and providers, health care facilities, clinical and academic researchers, purchasers/employer groups, and patients and their advocates. It would also require unifying and cross-referencing various databases, from public health entities' epidemiological and survey data to the claims and utilization data collected by public purchasers and private health plans.

## Who are Washington's women?

- Half of the 2,729,499 females living in Washington State in 1995 were between 25 and 64, and more than 1 in 4 was younger than 18.
- Nearly 9 in 10 Washington women were white, 5.7% were Asian or Pacific Islander, 3.1% were African American, and 1.9% were Native American. Less than 5% were of Hispanic descent.
- In 1990, 9% of Washington households were headed by women.
- Nearly 17% of Washington women ages 25 and older lacked even a high school diploma or GED. Nonwhite women were far more likely to lack education than were white women.
- About 54% of Washington women were employed in the paid labor force in 1990, compared with 69% of Washington men.
- Washington women employed full-time and year-round earned \$20,607 in 1990, compared with \$31,026 earned by men.
- Female-headed families with children younger than 18 had incomes about 32% that of married couples with children.
- More than a third of female-headed families in which the woman was younger than 65 had incomes below the poverty level.
- Nearly 16% of women ages 75 and older lived in poverty, about twice the level of women ages 65 to 74.



# Chapter 1 . Sociodemographics

Women's health is often a reflection of how they live. Whether they live in rural or urban places, their race, their ages, their incomes — all influence the health indicators that are the main focus of this report. Education and economic opportunities also affect social status, health status, and life style. These issues are explored in this chapter.

This report was completed early in 1997, when there was little contemporary information about the sociodemographic characteristics of women. This is because we depend on the U.S. census for much of our information about who we are and how we live. The last census was taken in April 1990, and the next one will be taken in April 2000. Washington State has grown rapidly during the 1990s, and a portrait based on 1990 data is probably not an accurate reflection of who we are today. We have used, where possible, more recent data gathered by surveys to augment the portrait created by census information.

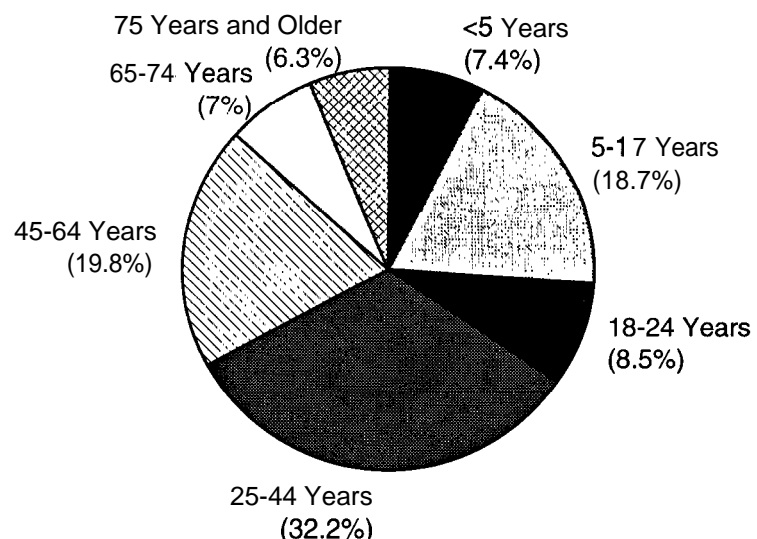
*"I can't think of any place else in the world where the community exists other than a reservation where we know each other.... We may not see each other all the time but we do care about each other."*  
— women of the Colville Indian Tribe focus group

## Age Composition

The age of any population contributes greatly to its current and future health care needs. When societies have slowing birth rates, they are said to be aging. The United States, Western Europe, and Canada are all examples of aging societies. Among the issues confronting aging societies are rising demands for medical treatment services, which are inherently more costly than preventive services.'

Information about age composition can also help identify other needs. For example, demographers usually think of those younger than 18 and older than 64 as being eco-

**Figure 1. Age Composition Of Washington Women, 1995**



*“They’re going to have to do something about teaching ... how to be a little more respectful of people with gray hair.”*

– focus group of Older Women in King County

nomically dependent on those ages 18 to 64 (the so-called working ages). The implications of being younger than 18 and not working, however, are considerably different from being economically dependent after having lived through the working ages.

There were 2,729,499 females living in Washington State in 1995. More than 1 in 4 was younger than 18. Fully half were in their working ages of 25 to 44. That year, close to 1 of every 7 Washington women was older than 65.

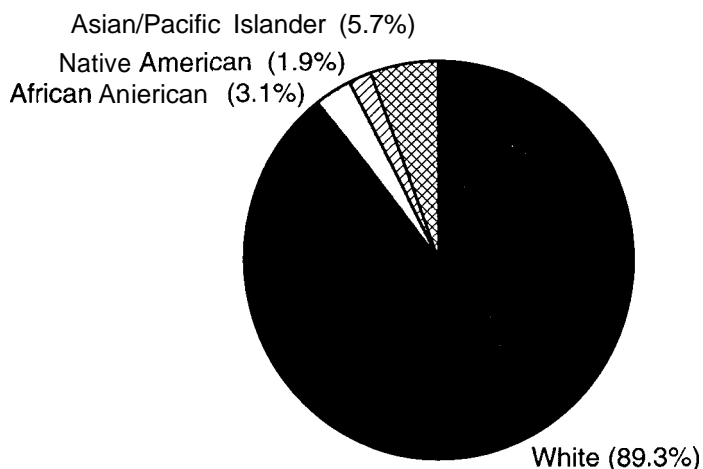
Another way to evaluate age composition is to calculate median age, or the age that divides a population in two equal segments, half older than the median, half younger. Median age has been rising steadily in Washington since 1980, when it was 30.6 among women and 29 among men. By 1995, Washington women’s median age was 35.1, compared with 33.3 among men. In Washington as elsewhere, women have higher median ages than men because they outlive men by 5 to 10 years.

## Race and Ethnicity

In the United States, the health of a given population is strongly influenced by that group’s racial composition. (“Race” in this report is presented as the five categories used by the U.S. Census Bureau: white, African American, Native American, Asian/Pacific Islander, and other. This grouping is increasingly under challenge, especially when health is the outcome of interest.\*)

Overall, Americans who are classified as white or Asian American have better health outcomes than do Native Americans or African Americans.<sup>3</sup> These patterns generally occur regardless of social class or

**Figure 2. Race Composition Of Washington Women, 1994**





poverty status. In 1994, 89.3% of Washington women were white, 5.7% were of Asian or Pacific Island descent, 3.1% were African American, and 1.9% were Native American.<sup>4</sup>

“Ethnicity” reflects the culture in which a person grows up and lives. Although the United States contains many ethnic groups, we use the Census Bureau’s definition of ethnicity: whether a person is of Hispanic origin. Because ethnicity and race are defined separately, people of Hispanic origin may be of any race. The link between health and ethnicity is less clear than is the link between health and race. Some research has shown, for example, that women of Hispanic origin may have better pregnancy outcomes than non-Hispanic women, despite their greater risk of being poor. Fewer than 5% of Washington women in 1994 were of Hispanic origin.

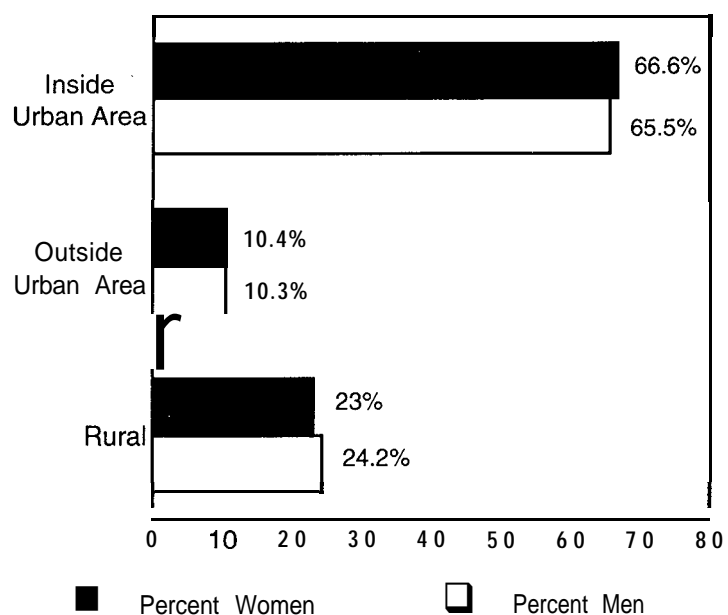
The various racial or ethnic communities making up Washington women have very different age compositions. Among white women, for example, nearly as many were 75 and older (6.7%) as were younger than 5. But 11.4% of African American women were younger than 5, as were 10.7% of Native American women and about 8% of Asian/Pacific Islander women. Hispanic women were the youngest of all: 14% were younger than 5, and only 3.3% were 65 and older.

## Geographic Distribution

Information about geographic origins gives us insight into social isolation. That is, women who migrated to Washington State from other places might be less likely to have the network of social support that is so important to health and well-being. At the time of the 1990 census, less than half of Washington’s female population was born in this state.

*“I feel this is very important ...to look for support from friendships, because otherwise one feels /one/y, isola ted.. ..It’s very difficult to be away from your native country.*  
— Hispanic Women in Toppenish focus group

**Figure 3. Washington Women and Men  
By Urban or Rural Residence, 1990**



*"Your small towns and your rural communities have a different set of circumstances and variables than you have in the city... You know I'm 15 miles out.... and what do I do if [my baby] can't breathe?"*  
- focus group of DSHS clients in Pacific County

Another question the 1990 census asked was where people lived 5 years earlier. Among Washington women, 45.9% had lived in the same house 5 years earlier, and another 28.4% had lived in a different house in the same county. So nearly three-fourths of Washington's female residents had experienced little or no mobility in the previous 5 years.

The urban/rural distribution of women and men is similar. Most live inside urbanized areas, about a fourth live in rural communities, and only 10% live outside urban areas. Whether people live in rural or urban communities influences their health status. The Census Bureau describes any incorporated place of fewer than 2,500 residents as rural; it calls non-rural places urban, and it makes a distinction between those who live "inside the urbanized area" (sometimes called central city residents) and those who live outside ("suburbanites"). Health services in general and specialty services in particular are concentrated in urban centers, and people who live in rural communities often must travel long distances to see health care providers.

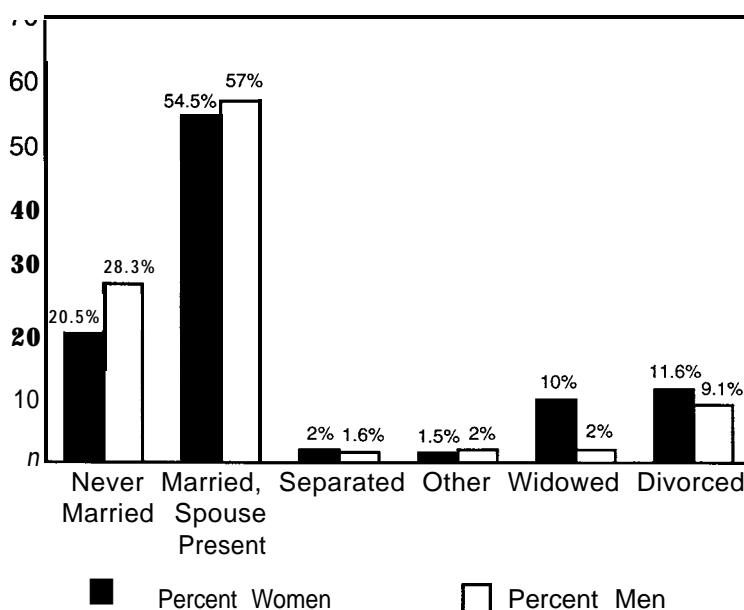
Whether Washington women are more likely to live in urban or rural communities tends to vary by age. The 1990 census showed that children

ages 5 to 14 and adults ages 45 to 65 were more likely to live in rural places. Young adults ages 15 to 24, working-age adults ages 25 to 44, and women ages 75 and older were more likely to live in urban centers.

## Living Arrangements

Women's living arrangements may have significant effects on their health. Women who are trying to care for children without the help of an adult partner may have less time to seek out health services than women who live alone or have other children or partners to help them.

**Figure 4. Washington Women and Men By Marital Status, Ages 16 and Older, 1990**



At the time of the 1990 census, 54.5% of women ages 16 and older were married, 11.6% were divorced, 2% were separated, and 10% were widowed. All but 3% of Washington women marry at least once.

Another way to evaluate the living arrangements of Washington women is to assess the composition of their households. In census parlance, a “household” consists of individuals sharing a living unit, such as a house, trailer, or apartment. The Census Bureau differentiates two basic types of households: family (related individuals sharing a dwelling); and non-family.

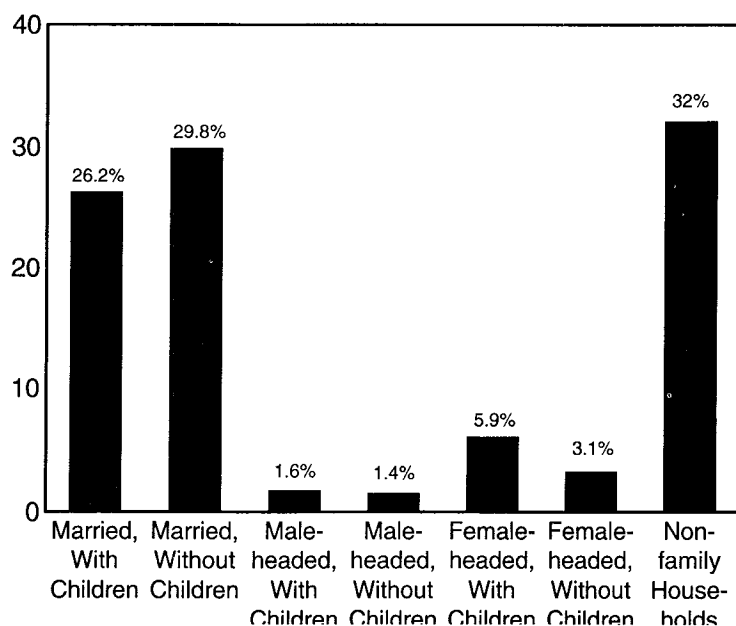
In 1990, 68% of Washington households were family households and 32% were non-family households consisting of single persons or unrelated individuals.<sup>5</sup> Of the family households, 26.2% were married couple households, including children younger than 18.

In Washington and in the nation as a whole, female-headed households with children comprise large shares of non-white households. In the 1990 census, female-headed families with children younger than 18 accounted for 5.9% of all the families in the state. Among whites, that fraction was slightly lower, 5.3%, and among Asian/Pacific Islander households, it was slightly higher, at 6.8%. The highest proportions of female-headed households were among African American households (16.1%) and Native American households (15.9%). Among Hispanic households, 10.5% were female headed and included children younger than 18.

Among the non-family households, nearly 5% of all Washington households identify themselves as unmarried partners. In 1990, this type of household was slightly more common inside urban localities (5% of all households) than outside central urban places (4.1%) or in rural areas (3.9%). Of these households,

*“I also come from a very traditional family and we nibble on a little bit of herbs, we put them in our pockets ... and we burn a lot of sea grass over ourselves and keep ourselves healthy.”*  
— women of the Colville Indian Tribe focus group

**Figure 5. Household Composition  
In Washington, 1990**



*“Some people don’t know about the clothing bank or the food bank.... We have them, they’re not that wonderful, but they’re here and we have them.”*  
— focus group of DSHS clients in Pacific County

95% consisted of male and female partners, 2.7% of male partners, and 2.3% of female partners. Unmarried partners were found in 10.4% of Native American households, 6.7% of Hispanic households, 6% of African American households, and 5.8% of other households. Households of unmarried partners were least common among Asian/Pacific Islanders (3.5%) and whites (4.5%).

## Socioeconomic Status

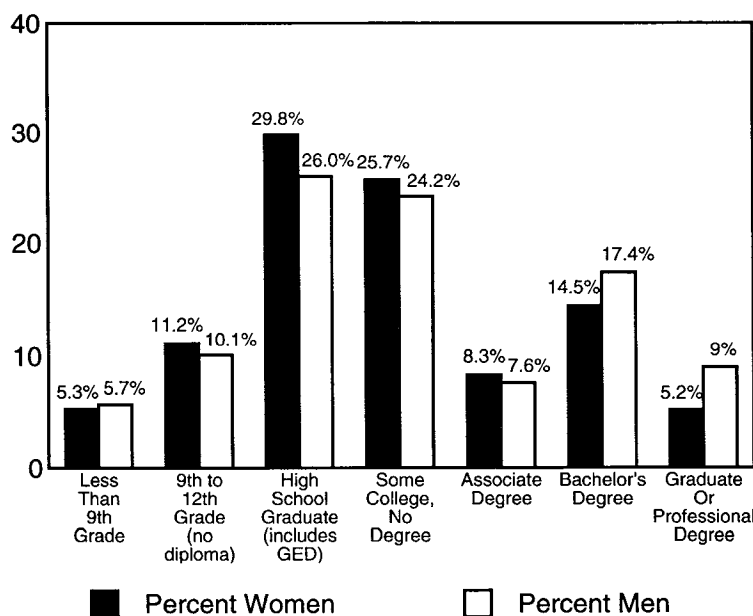
Socioeconomic status (SES) may best be thought of as a woman’s chances for living a comfortable life, including her chances of enjoying optimal health. We present five factors that help determine those chances: education; employment; occupation; income; and poverty.

**Education.** It is increasingly clear that, of the five determinants of SES, education is the paramount one. In the postmodern economy of the late 20th century, a woman’s educational attainment is often the single most powerful predictor of her occupation and income and, consequently, her health.<sup>6</sup>

In 1990, Washington women were consistently over-represented

among those with the least education and under-represented in the ranks of the most educated. Nearly 17% of women age 25 and older lacked even a high school diploma or general equivalency diploma (GED), compared with 15.8% of Washington men.<sup>7</sup> Another 25.7% of Washington women had experienced some post-secondary education but lacked a degree. About 8% of women had received an associate’s degree (usually awarded at the completion of 2 years’ post-secondary education). Only 14.5% of women reported having earned a bachelor’s or graduate degree, and only 5.2% held a graduate

**Figure 6. Educational Attainment, Ages 25+ Washington Women and Men, 1990**



or professional degree, compared with 9% of men.

Women living in the state's urban areas were more likely to have advanced education than those living in rural places: 84% of Washington's "urban women" had at least a high school diploma, and 55% had some college. Among "rural women," 81.6% had high school diplomas and 48.2% had some college. As is true nationwide, there were marked disparities in educational achievement by race. Nearly 85% of white women ages 25 and older living in Washington in 1990 had at least a high school diploma, compared with only 71.2% of nonwhite women. The racial gap in education was least evident among the most educated women: 20% of white women and 17% of nonwhite women held at least a bachelor's degree.<sup>8</sup>

**Employment.** The census measures employment by grouping people age 16 and older as being in the Armed Forces, being employed, being unemployed (a category that implies they are looking for work), or not being in the paid labor force. Washington women ages 16 and older were far less likely than men to be in either the Armed Forces or in the paid labor force.

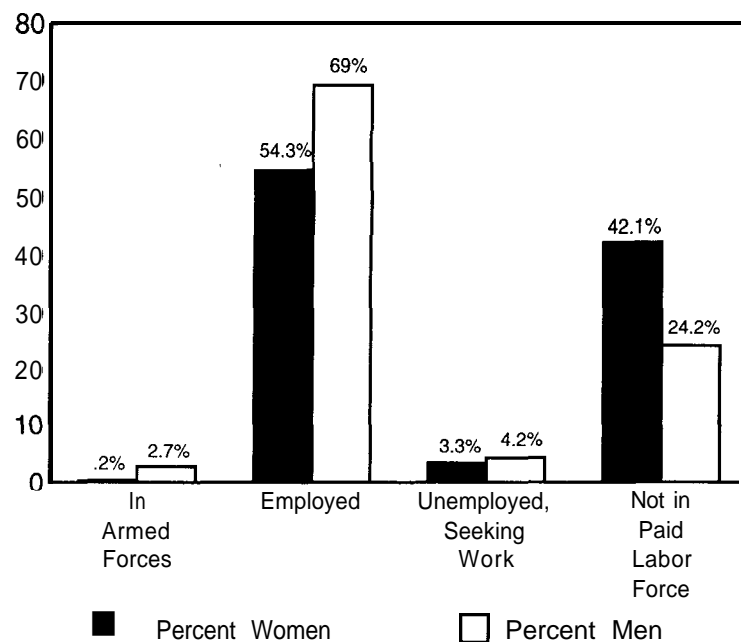
In 1990, about 54% of Washington women were employed, compared with 69% of men. About 42% of women and 24% of men said they were not in the paid labor force, a figure that includes both stay-at-home parents and retirees. Women in urban areas were more likely to be employed and less likely to be out of the paid labor force.

The 1990 census revealed a substantial variation in labor force participation in terms of women's ages. Employment rose steadily from 47.5% of those ages 16 to 19 to 66.4% of women ages 20 to 24 and 70.4% of women ages 25 to 54. After age 54, however, employment fell, and only 41.6% of those age 55 to 64 were

*"You go in there and explain to people I am homeless, I need a job so I can get out of this homeless situation. They are not going to hire you because you are homeless."*

— focus group of Homeless Women

**Figure 7. Washington Women and Men Employment, Ages 16 and Older, 1990**



*"Some times living in society there are so many stresses. For example, if you don't have work how can you keep your mind stable?"*

*-focus group of Ethnic Chinese Women*

in the paid labor force. Overall, fewer women than men worked full time. Nearly 43% of employed women worked full-time, or at least 35 hours a week, compared with nearly 70% of men. About 18% of women worked 15 to 34 hours a week, and another 4.2% worked 1 to 14 hours a week.

An important public policy issue concerns employment of parents of young and school-age children. Most parents of Washington children seem to have substantial attachment to the work force. The Census Bureau computes employment status only for mothers, not for fathers. In 1990, 53.7% of Washington mothers with children younger than 6 were employed or in the armed forces, as were 72.4% of mothers of children ages 6 to 17.

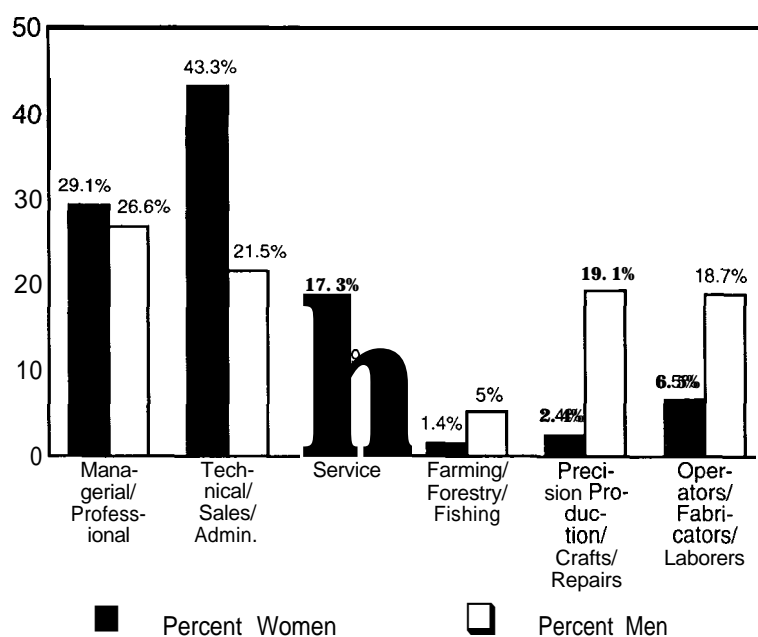
**Occupation.** Among employed Washington women, 29.1% were in managerial occupations, including teachers and health treatment professions, compared with 26.6% of men. Another 43.3% were in technical occupations, including both health technologists and administrative support categories, and 17.3% were in service occupations.

As with education, there is considerable variation among Washington women's occupations by race. Among women of all races and ethnicity,

the largest proportion work in technical occupations. But white women are next most frequently in managerial occupations, then in service ones. African American women follow a similar pattern. Native American and Hispanic women are next most frequently in service occupations, then managerial ones. Asian/Pacific Islander women are found in about the same proportion in service and managerial positions.

Substantial differences also exist between the industrial sectors where women work and those where men work. The 1990 census showed that men were far more likely to work

**Figure 8. Washington Women and Men Occupations, Ages 16 and Older, 1990**



in the heavily unionized sectors of agriculture, forestry, and fisheries, in mining and construction, in manufacturing, or in utility-related sectors. Women are concentrated in the trade and services sectors that traditionally are less intensely unionized and where wages tend to be lower.

**Income.** As is true nationwide, there is a large gap between the income of Washington men and women. In 1989, Washington women working year-round and full-time earned a median income of \$20,607, compared with \$31,026 for men.<sup>9,10</sup> The income gap was widest between white men and women and smallest between African American men and women.

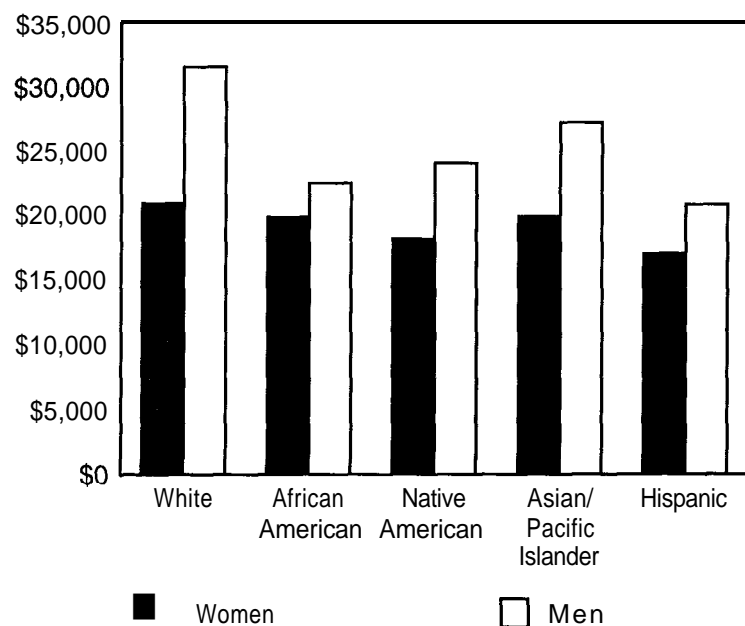
Female-headed families have the lowest incomes of any household type in Washington. In 1989, female-headed families with children younger than 18 had an average income of \$13,077, compared with \$41,389 for married-couple families with children.<sup>11</sup> Put another way, female-headed families with children had incomes that averaged 32% of the income of married-couple families. Among female-headed families, income distribution differed sharply by race. About 35% of white female-headed families and 31% of Asian/Pacific Islander female-headed families had incomes of \$25,000 or more. But only 15% of Native American families headed by women, only 17% of Hispanic families, and only 25% of African American families earned at this level.

**Poverty.** Poverty is a term used to identify people whose income is not adequate to feed the number of people in a family. The calculation of poverty changes annually, based on a formula that assumes that 30% of an individual's or family's income goes for food. If 30% of wage income does not meet the federal annual estimate of how much a market basket of food will cost for a given family size, then the family (or individual)

*'[When I get sick] I do one of two things, depending on whether I am rich or not. If I can get like a day or two off of work and I have money to eat, then I will sleep for 15 hours.... If I don't have money then I suffer and am sick for a few weeks. That is what usually happens.'*

**-Lesbians focus group**

**Figure 9. Median Income by Gender and Race Washington Year-long, Full-time Workers, 1989**



*"A lot of people just don't have a place to go."*

— focus group of Homeless Women

is identified as having poverty-level income. Once a determination of poverty has been made, eligibility for public assistance often follows. In Washington, for example, a pregnant woman whose income is below 185% of poverty (almost twice the poverty level) is eligible for Medicaid, the publicly funded health insurance program.

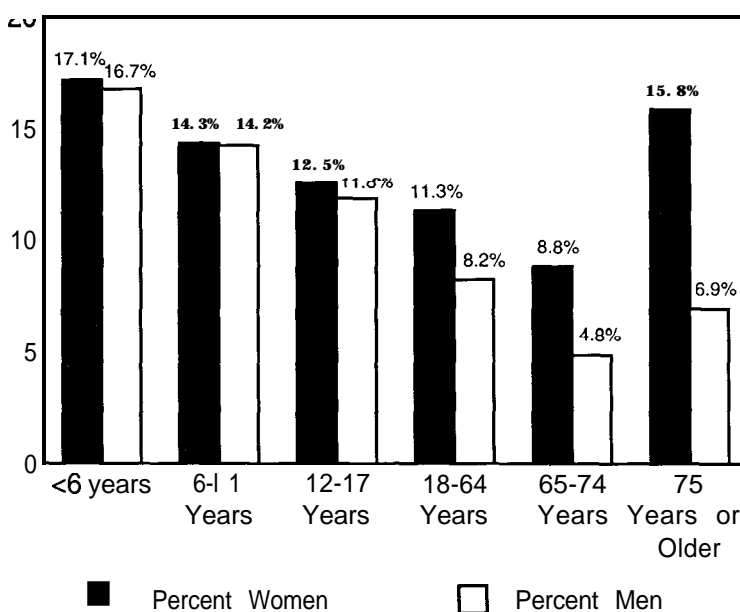
Given the gap between incomes of female-headed families and others, it is not surprising that in 1990, 34.5% of families headed by women younger than 65 had incomes below the poverty level, compared with 15% of male-headed families and 5% of married-couple families. About 1 in 5 nonfamily households was poor.

In Washington and other states, there is a steady decline in poverty among both men and women until age 75 and older. Then poverty rates rise among men, from 4.8% for those age 65 to 74 to 6.9% among those age 75 and older. But among women, poverty rates nearly double, from 8.8% of women age 65 to 74 to 15.8% of those ages 75 and older. Some of this precipitous increase may be explained by the higher levels of widowhood among the oldest women: a spouse's pension benefits often cease with that

person's death. Poverty rates among the oldest Washington women in 1989 were essentially the same as those among the youngest children.

Many Washington residents are among the so-called working poor, whose incomes are not sufficient to lift them and their families above the poverty threshold. In 1989, 60.5% of household heads in poor married-couple families and 48.7% of women heading poor households had been in the paid labor force. More than 3 in 5 households in poverty were headed by someone with at least a high school education. About 54.3% of poor female-headed households

**Figure 10. Poverty by Gender and Age  
Washington, 1989**





received public assistance through programs other than Social Security.

About 14% of Washington children lived in poverty in 1989, about half the national average. Children living in female-headed households were most likely to be poor. In Washington, 54.4% of children younger than 6 who lived in these families were poor, as were 29.3% of children age 6 to 17. Poverty rates among children living in male-headed households were less than half these levels: 21.2% of children younger than 6 and 13.1% of school-age children. Among children living in married-couple households, 5.7% of those younger than 6 and 3.9% of older children were poor.

## Summary

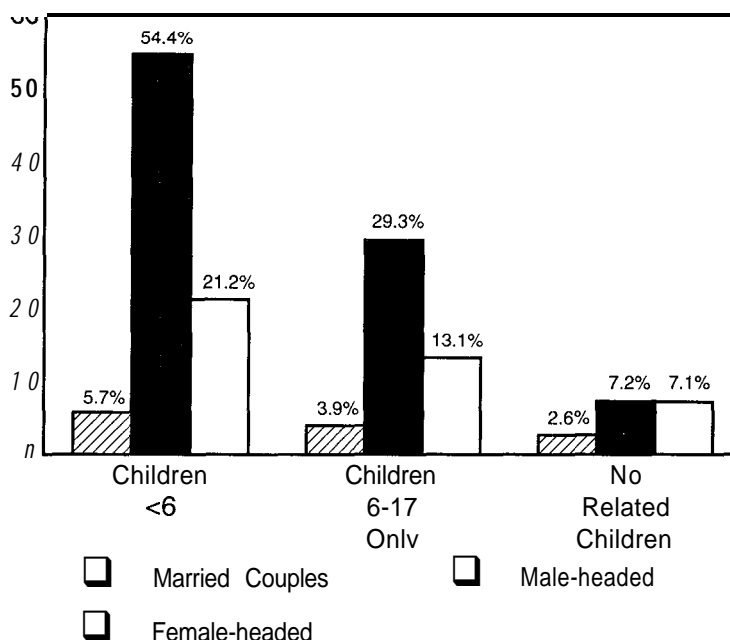
What emerges from these statistics, many of them dating back nearly a decade, is a picture of a state where women are less well educated and less well off than men and where, among women themselves, those who are African American, Native American, or Hispanic may be consistently less well off than their white or Asian/Pacific Islander sisters. As a group, Native American, African American, and Hispanic women are younger.

One implication of these findings is that younger women may be less well off than older ones. That appears to be true except at the oldest ages, where the poverty rate is as high as it is in childhood. We will want to keep these differences in mind as we explore information about health status and health-related behaviors in the remainder of this report.

*"Just recently I went through a real major incident where I had to go see a doctor and I was fortunate to have enough people around that really care about me and made sure that [my] family and everyone were involved."*

— focus group of African American Women

**Figure 11. Poverty by Family Type And Presence of Children, Washington, 1989**



## Notes

<sup>1</sup> Terris, Milton. Public Health Policy for the 1990s. *Annual Review of Public Health*, Volume 11, 1990, pages 39-52.

<sup>2</sup> Hahn, RA, Stroup, DE Race and ethnicity in public health surveillance: criteria for the scientific use of social categories. *Public Health Reports*, 109 (1), 7- 15. McKenney, NR, Bennett, CE. Issues regarding data on race and ethnicity: the Census Bureau experience. *Public Health Reports*, 109(1), 16-25. Cooper, RS. A case study in the use of race and ethnicity in public health surveillance. *Public Health Reports*, 109 (1), 46-52.

<sup>3</sup> U.S. Department of Health and Human Services (1985). *Report of the Secretary's Task Force on Black and Minority Health*. Washington, DC: U.S. Government Printing Office.

<sup>4</sup> The Washington State Office of Financial Management, the agency that computes population estimates and projections, calculated race by gender by age projections only through 1994.

<sup>5</sup> The U.S. Census Bureau does not report household composition by gender except as noted below.

<sup>6</sup> Liberatos, Penny, Bruce G. Link, Jennifer L. Kelsey. The measurement of social class in epidemiology. *Epidemiologic Reviews*, Volume 10, 1988, pages 87-121.

<sup>7</sup> The Census Bureau assumes — incorrectly, as it turns out — that most Americans have completed their lifetime education by age 25.

<sup>8</sup> The small number of women in any one racial or ethnic group made more detailed analysis impossible. Based on the pattern of race by ethnicity seen in the 1990 census, probably 42% of Hispanic women are in the white group and 58% are in the non-white group.

<sup>9</sup> The 1990 census is taken in April, and questions about income and poverty refer to the previous calendar year, 1989.

<sup>10</sup> The median income is one which identifies the midpoint of income distribution: 50% earned less and 50% earned more.

<sup>11</sup> Because so few male-headed families were enumerated overall, when they were subdivided into rural and urban, as in this comparison, the numbers dropped below the threshold established to maintain confidentiality. Consequently, male-headed families were excluded from this comparison.

# What are Washington women doing for their health?

- Washington State women in 1994 reported significantly more days of poor mental and physical health in the previous month than did men. One possible explanation is that, as a group, women tend to be older than men, and the proportion of people experiencing poor health rises with age.
- Washington women were significantly more likely than men to engage in regular physical activity. But nearly half of Washington women reported having a sedentary lifestyle, one that lacks regular leisure-time physical exercise.
- Women living in Washington were more likely than men to follow the recommendation that they eat at least five servings of fruits and vegetables daily, but only a fourth of the state's women were following that dietary recommendation.
- About a fourth of Washington women were overweight, but all but the oldest group of women (75 years and older) reported that they were using a combination of exercise and calorie reduction to lose weight.
- Washington women were significantly less likely than men to have had a blood test for AIDS or to believe they were at increased or high risk of contracting the disease.



## Chapter 2. Health Status and Lifestyle Choices

In this chapter, we explore the health status and lifestyle choices of Washington women. The information in this chapter comes from the 1994 Washington State Behavioral Risk Factor Surveillance System (BRFSS), a state-based, national data collection system, collecting self-reported information.<sup>1,2</sup> There are at least two limitations of the BRFSS data. First, the method used to select respondents is random digit dialing of telephones. Thus, while the data are presented as representative of Washington State adults ages 18 and older, in fact, they represent only adults living in the 96-98% of Washington households with telephones. Secondly, the number of people reporting given behaviors in some categories is very small. For this reason, we can make few comparisons about certain types of behavioral risk-taking among different racial and ethnic groups of Washington women. Where possible in this chapter, we gauge behavioral risk-taking among Washington State women and men against targets set out in *Healthy People 2000*, the inventory of health objectives for the nation.

*“Personally, I don’t have very complicated problems. I try to eat things that are healthy for me and I have a lot of friendships and think positively”*

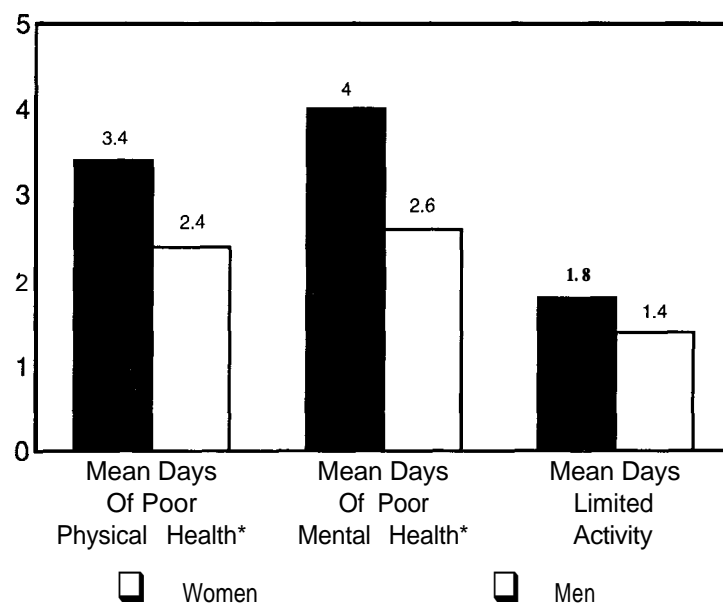
— Hispanic Women in Toppenish focus group

### Poor Health

One subjective measure of health is the number of days people say they had been in poor physical or mental health, or had limited their usual activities, in the past month. In Washington State 1994, women reported having a significantly greater number of days of poor physical and mental health than did men in the past 30 days. Women reported more days of limited activity than did men, but the difference was not significant.<sup>3</sup>

One possible explanation of the higher frequency of poor health experienced by Washington women may be their age composition. Rela-

**Figure 12. Days of Poor Health in Past Month  
Washington State Women and Men, 1994**

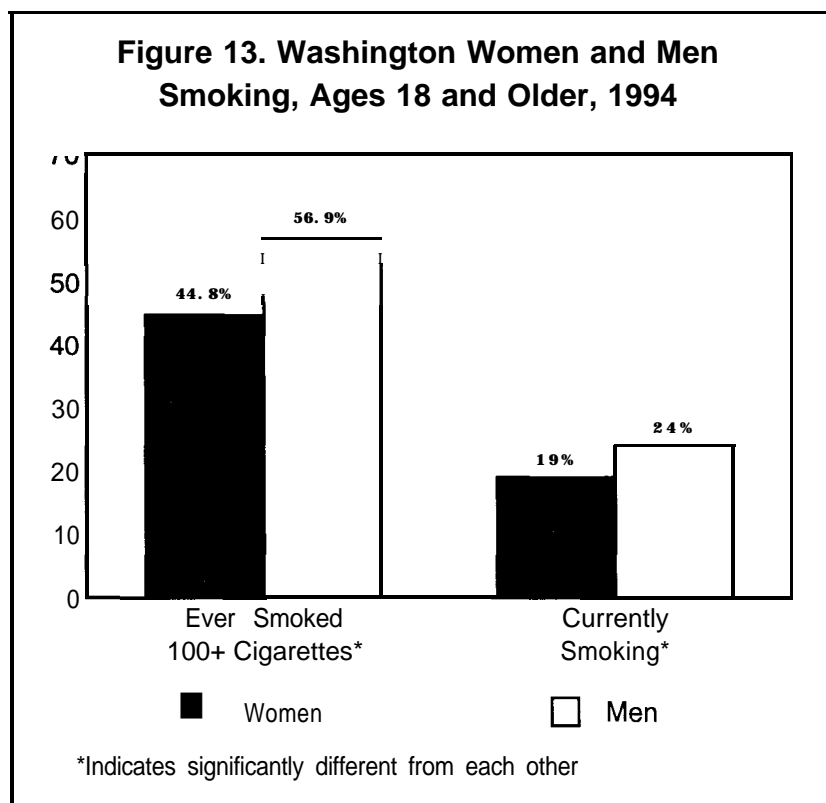


*“When I told [my doctor] I quit smoking, he got out his prescription pad. I said I don’t want any of your little helpers. It’s just replacing one bad habit with another one.”*  
 -focus group of Older Women in King County

tive to men, women are older. The difference in the number of men and women is particularly marked at the oldest ages, 65 years and older. This is also the period in life when poor health is more likely to manifest itself. In addition, by age 75 more than 15% of Washington women are living in poverty and thus may be unable to engage in behaviors — seeing a physician when needed, purchasing recommended medications, and eating appropriate food- that would optimize their health status.

## Behavioral Risks

Risk-taking behavior and lifestyle choices have been shown to be major factors in illness and death. This research was recently summarized and the authors concluded that fully half of deaths occurring in 1990 could be attributed to external factors such as tobacco, diet and activity patterns, alcohol, infectious agents, and behavioral risk-taking<sup>4</sup>. (The other 50% relate to biological risks that are currently poorly understood or not amenable to available interventions.) BRFSS data are helpful in assessing the magnitude of behavioral risks Washington women are taking.



**Smoking.** For more than 30 years, cigarette smoking has been identified as a major factor in chronic diseases, including heart disease, stroke, and cancer. Cigarette smoking also is strongly linked with complications of pregnancy. More recent evidence indicates that smoking generally commences before the age of 20 and, once begun, is one of the most difficult addictions to end. Smoking is implicated in so many adult health problems that *Healthy People 2000* includes an entire section devoted to tobacco-related objectives.

Nationally about 51.8% of men and 41.9% of women have ever

been smokers.<sup>5</sup> Comparable figures for Washington are somewhat higher, 44.8% of women and 56.9% of men. The difference in the share of Washington women and men who have ever smoked is significant. One of the **Healthy People 2000** tobacco-related objectives is that no more than 15% of U.S. adults age 20 and older be smokers. In 1994, significantly more Washington men than women were current smokers, but in most years, smoking rates are about the same.

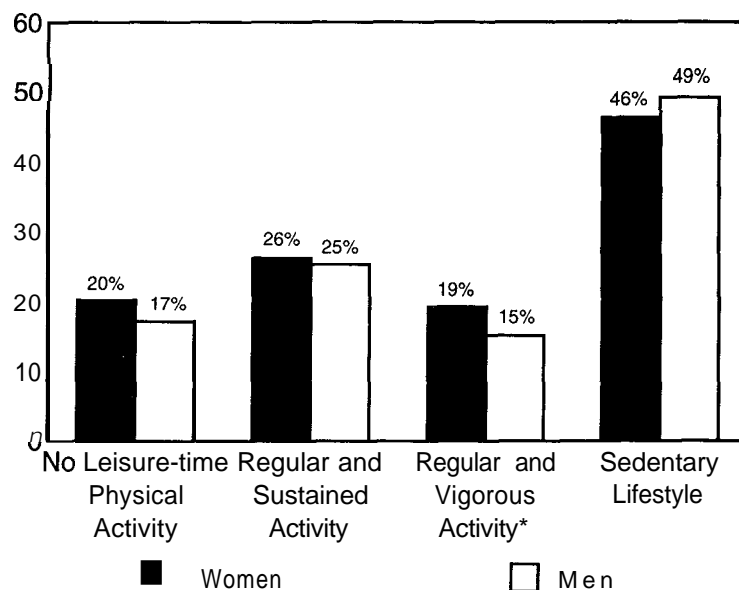
**Alcohol abuse.** Information about the health impact of alcohol tends to be mixed: moderate alcohol consumption is sometimes shown to have health benefits, but alcohol abuse is an important factor in many deaths from motor vehicle injuries and cirrhosis, and it appears to be a factor in cardiovascular disease as well. Although questions about alcohol consumption were included in Washington state's 1993 BRFSS, the number of women reporting that they engaged in any of three risk-taking behaviors — chronic drinking, binge drinking, or drinking and driving — was so small that reliable rates could not be computed.

**Activity patterns.** Considerable evidence shows the importance of regular physical activity throughout the life course. **Healthy People 2000** cites exercise as a means of improving mental health and reducing obesity and such chronic diseases as cardiovascular disease, osteoporosis, and non-insulin dependent diabetes.

In 1992, 20% of Washington women reported no leisure time activities, compared with 17% of men; the difference is not significant. These rates are better than the national rates of 26.5% among men and 30.6% among women. But neither the national rate nor the Washington rate is as low as the **Healthy People 2000** objective, which is that no more than

*"I have a friend who very seldom gets out to walk. And I keep telling her, put that car in the garage and leave it there and walk..."*  
— focus group of Older Women in King County

**Figure 14. Washington Women and Men  
Patterns of Exercise, Ages 18 and Older, 1994**



\*Indicates significantly different from each other

*“Once you cook the broth the vegetables soak up the nutrition of the meat. Therefore . . . you don’t have to eat the meat. The meat is all full of no thing.. .”*  
 — focus group of Ethnic Chinese Women

15% of the adult population lack any regular leisure-time physical activities.

When a person’s lifestyle includes no physical activity either at work or at home, it is said to be sedentary. Healthy **People 2000** sets a target that no more than 15% of adults live such a lifestyle. Achieving that objective, however, seems remote; nationally, 56.2% of men and 57.1% of women had a sedentary lifestyle. The proportions are lower in Washington.

Slightly more than half of Washington adults do get regular exercise, but their activities are not consistent with national objectives. **Healthy People 2000** calls for at least 30% of people to engage in regular, sustained physical activity — light to moderate physical activity lasting at least 30 minutes — at least three times a week. In Washington, 26% of women and 25% of men met this objective, exceeding national levels of 19.7% of women and 20.4% of men.

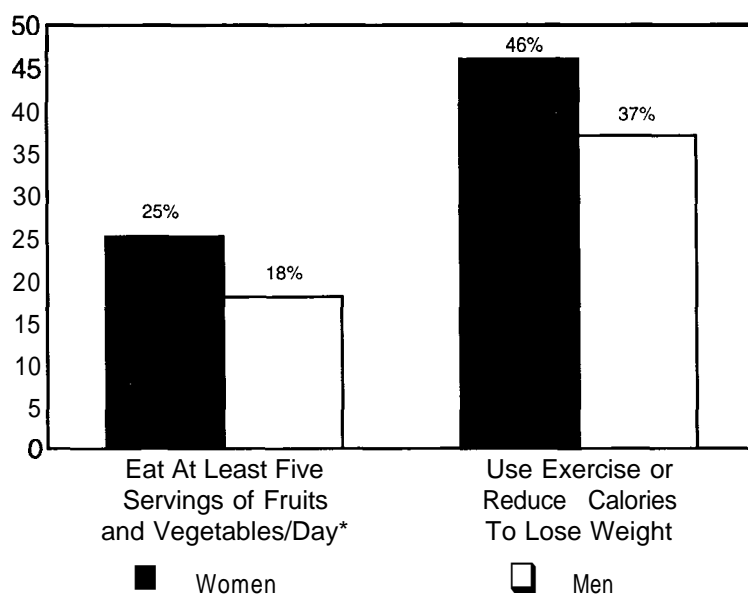
**Healthy People 2000 also** has an objective that at least 20% of people engage in regular, vigorous activity. These are activities that occur at least three times a week, with at least 20 minutes at 50% or more of a capacity needed to sustain cardiovascular fitness. Nationally, 15% of women, but only 12.5% of men, met this target. In Washington, 19% of women met it, compared with 15% of men; the difference is statistically significant.

Walking was the most important activity for Washington women who exercised. In 1994, it was the choice of about 42% of women, while 7% chose aerobics classes.

### Diet and weight control.

Nutrition and eating habits affect health at all stages of life. Dietary patterns can exacerbate or reduce the risk of chronic diseases, such as high blood pressure and other cardiovascular illnesses, diabetes, osteoporosis, and certain cancers. The link between

**Figure 15. Washington Women and Men Diet and Weight Control, Ages 18+, 1994**



\*Indicates significantly different from each other



nutrition and health is so strong that new recommendations are made frequently in terms of dietary modifications that can reduce the risk of certain diseases or generally contribute to improved health.

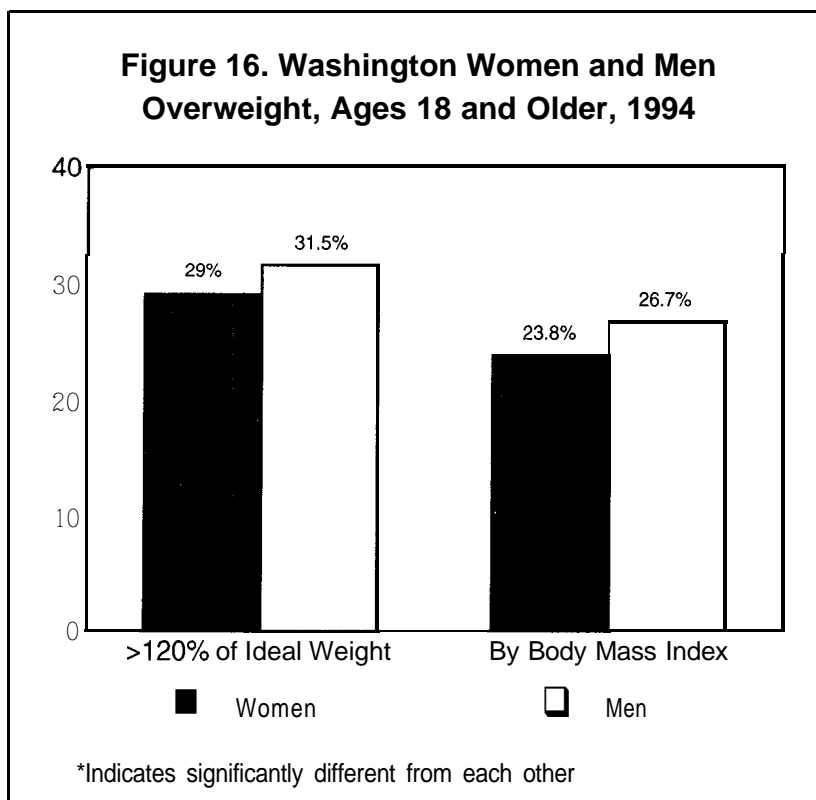
Women appear to pay more attention to dietary information in the mass media than do men. For example, the “5 A DAY for Better Health Program” is sponsored by the National Cancer Institute and the Produce for Better Health Foundation. The goal of this program is to increase the per capita consumption of fruits and vegetables to five servings a day by 2000. Nationally, 17.8% of men and 26.3% of women follow that recommendation. In Washington, women are also more likely to follow this guideline: 25% of them eat five or more servings of fruits and vegetables each day, compared with only 18% of men, a significant difference.

Nearly half of Washington women are increasing their exercise levels or reducing calories or fat intake to control their weight, as are 37% of Washington men.

There are two ways to measure who is overweight. One measure compares a reported weight to an ideal based on height and age. This method uses the Metropolitan Life Insurance Company’s tables of ideal weight by gender and age, which reflect 1959 norms. A second measure, the body/mass index, compares an individual’s height to weight. Both measures should be interpreted with caution because weight as measured in the BRFSS is self-reported and so may be under-reported.

In the United States overall, 32.7% of men and 29.8% of women weighed 120% or more of their ideal weight, and 28.4% of men and 25.2% of women were overweight in terms of their body/mass index. In Washington, men are more likely to be

*“We were raised on  
pota toes with gravy  
and stews and side  
breads and  
macaroni. ” —  
Women of Colville  
Indian Tribe focus  
group*



*"I saw a doctor and he just ragged on me for not eating. He said it was my job to make sure that I eat and he didn't go into the factors of why I don't eat or why I had problems eating or anything like that."*  
 — Lesbians focus group

overweight than women, although the difference is not statistically significant: about 32% of men and 29% of women weighed 120% or more of their ideal weight, and 27% of men and 24% of women were overweight as measured by the body/mass index.

On average, about half of Washington women were trying to lose weight. The very youngest group of women (ages 18 to 24) and the very oldest (ages 65 and older) were less likely to be trying to lose weight than those between the ages of 25 and 64. The share of women trying to lose weight is greater than those who are objectively overweight.

**AIDS-related behaviors and attitudes.** In addition to injuries and chronic diseases, AIDS is a major cause of premature deaths in the United States. The Washington State 1994 BRFSS asks three questions about AIDS testing and risks, and women differed significantly from men on 2 of the 3 measures.

Nearly 43% of Washington men and 36.2% of Washington women reported having had a blood test for AIDS. In response to other questions concerning AIDS, 5% of Washington women and 8% of men said they had a

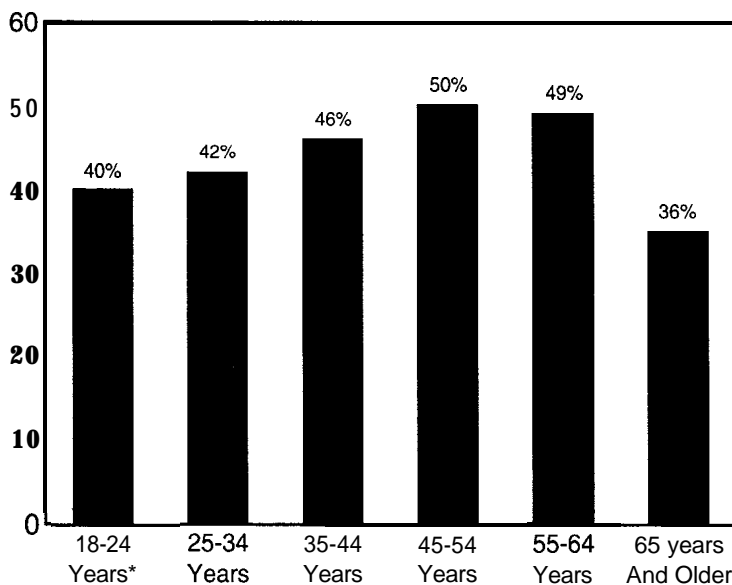
medium to high chance of getting the virus within the next year.

More men than women reported having a greater risk of getting the virus than they had a year before; this is the only measure where women and men are not significantly different in their responses.

## Summary

Washington women report more days of poor physical or mental health than do men. But it seems unlikely that the difference can be explained by the kind of behavioral risks measured in

**Figure 17. Washington Women by Age Trying to Lose Weight, 1994**



\*indicates significantly different from each other

Washington State's Behavioral Risk Factor Surveillance System. Women in Washington are less likely than men to engage in behaviors that might contribute to poor health, such as smoking or drinking excessively. They are more likely to eat recommended amounts of fruits and vegetables and to exercise vigorously. Although fewer than 30% of Washington State women are objectively overweight, at least 40% of all but the oldest women report they are trying to lose weight.

## Notes

<sup>1</sup> Washington State Department of Health, Center for Health Statistics, Behavioral Risk Factor Surveillance System, supported in part by U.S. Centers for Disease Control and Prevention Cooperative Agreement U58/CCU002118-10, 1994.

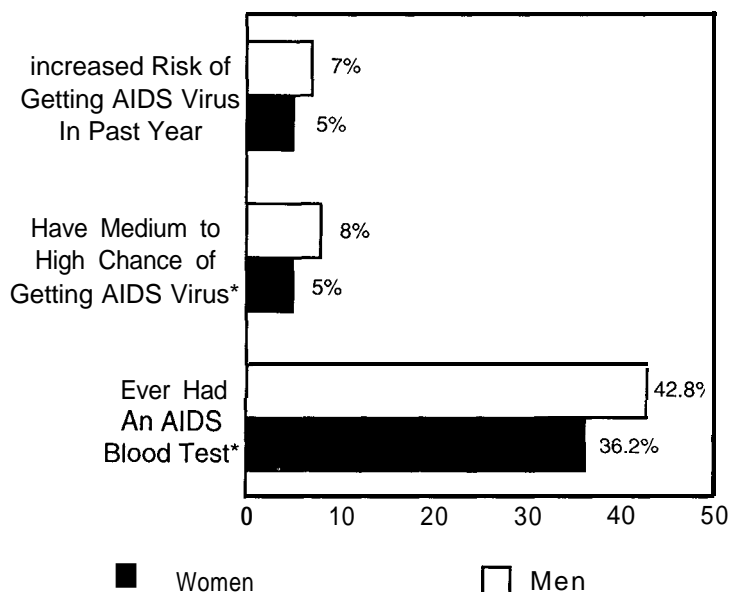
<sup>2</sup> Gentry, EM, Kalsbeek WD, Hogelin GC, Jones JT, Gaines, KL, Foreman MR *et al.* The behavioral risk factor surveys, Part II. Design, methods, and estimates from combined state data. *American Journal of Preventive Medicine*, 1985; 1; 9-14

<sup>3</sup> 95% confidence intervals were computed for this and all other measures in this chapter. When two rates have confidence intervals that do not overlap, those rates are called significantly different from each other. Confidence intervals for all measures are given in Appendix A.

<sup>4</sup> McGinnis JM, Foege, WH. Actual causes of death in the United States. *Journal of the American Medical Association*, 270(18), 1993: 2207-2212.

<sup>5</sup> The BRFSS defines a smoker as anyone who has smoked 100 or more cigarettes (about five packs) during the lifetime.

**Figure 18. Washington Women and Men AIDS-related Measures, Ages 18 +, 1994**



\*Indicates significantly different from each other

*"I usually don't get sick 'cause God watches over me."*  
— focus group of African American Women

# How do Washington women access health care?

- In Washington, 10% of women had no health insurance in 1994, and 12% of women were unable to see a health professional in the previous year because of cost.
- Among Washington women, 90% had a usual source of health care, compared with 78% of men. Women ages 18 to 34 were significantly less likely to have a usual source of care, while those ages 65 and older were more likely to have one.
- Use of mammography and Pap smears was significantly lower among Washington women ages 65 and older (Pap smear) or ages 70 and older (mammography), those with less than a high school education, or those with annual incomes lower than \$15,000.
- Women whose deliveries were reimbursed by Medicaid were more likely to report their most recent birth as unintended.
- Abortion rates have fallen among Washington women age 15 to 44, but African American and Asian/Pacific Island women had significantly higher abortion rates than did white women.
- First-trimester prenatal care rates improved in the early 1990s for all Washington women, but white women received such care at levels significantly higher than did non-white and Hispanic women.
- The proportion of pregnant women in Washington receiving late or no care also fell dramatically in the early 1990s, but significant differences persisted between very low rates of white women and higher rates of non-white and Hispanic women.



## Chapter 3. Health Care Access

The first two chapters of this report have described the context of Washington women's lives and some of the behaviors that may affect their health. Now the focus shifts to how women access health care. There are several ways to measure access.

The methods we use include participation in a health care insurance plan, ability to see a health care provider when needed, use of preventive services, and ability to access care for diabetes and for reproductive health services.

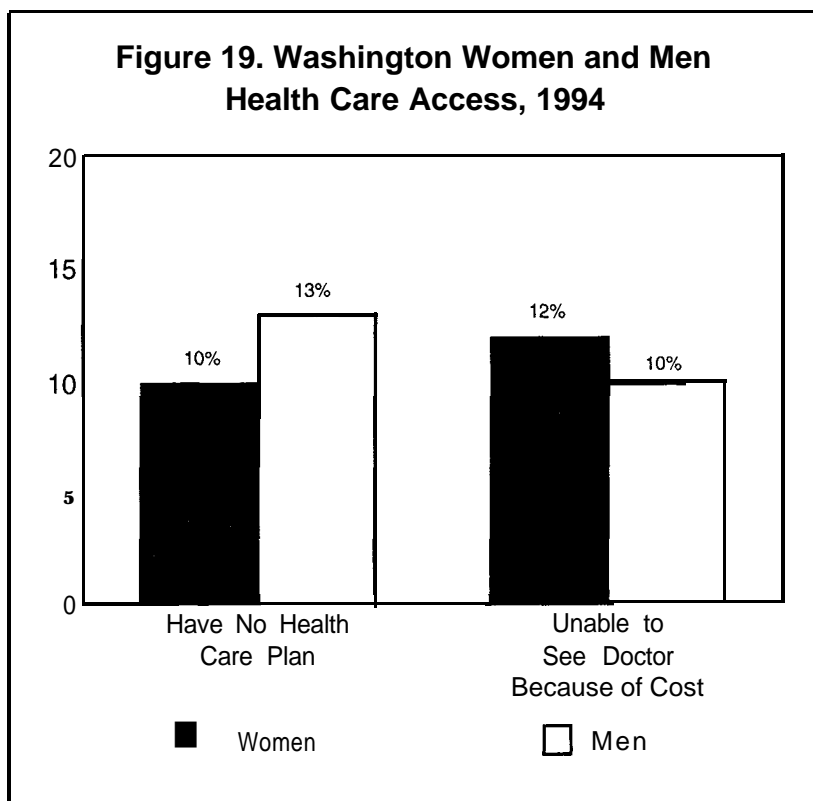
Much of the information in this chapter comes from the 1994 Behavioral Risk Factor Surveillance System. We obtained information about abortion utilization and prenatal care from public use data provided by the Washington State Department of Health Center for Health Statistics.

### Ability to Access Care

In 1994, 10% of Washington women did not participate in a health care plan, which is commonly referred to as having health insurance.<sup>1</sup> Among Washington men, 13% did not participate in a plan. These rates are not statistically different from each other. The rates of uninsured men and women in Washington are slightly lower than for the United States as a whole, 13.3% of men and 11.5% of women.<sup>2</sup>

But participating in a health plan does not always mean that an individual can afford the other costs of seeing a health professional, such as copayments for medicines and supplies. When asked if they had been unable to see a doctor because of costs in the previous year, 12% of all Washington women, but only 10% of

*"I'm in a managed care plan and I don't know if I've ever seen my doctor. Every time I've gone, it's somebody different. But with my experience under the fee for service, I couldn't afford the out-of-pocket expenses, so we went to managed care."*  
-focus group of African American Women



***“If it wasn’t for Indian Health Services, a lot of people would not be able to afford the health care.”***  
**— Women of the Colville Indian Tribe focus group**

men, said they had had that experience. About 59% of women unable to afford care had health care coverage.

Another way to measure health care access is to determine whether people have a usual source of care. On this measure, Washington women have more access than do men: 90.2% of women had a usual source of care, compared with 78.1% of men, a statistically significant difference. Washington women are more likely to have a usual source of care as they grow older. In 1994, 83% of women ages 18 to 24 reported having a usual source of care, compared with 94% of Washington women ages 65 and older — not an unexpected finding given the national policy of assuring widespread coverage through Medicare.

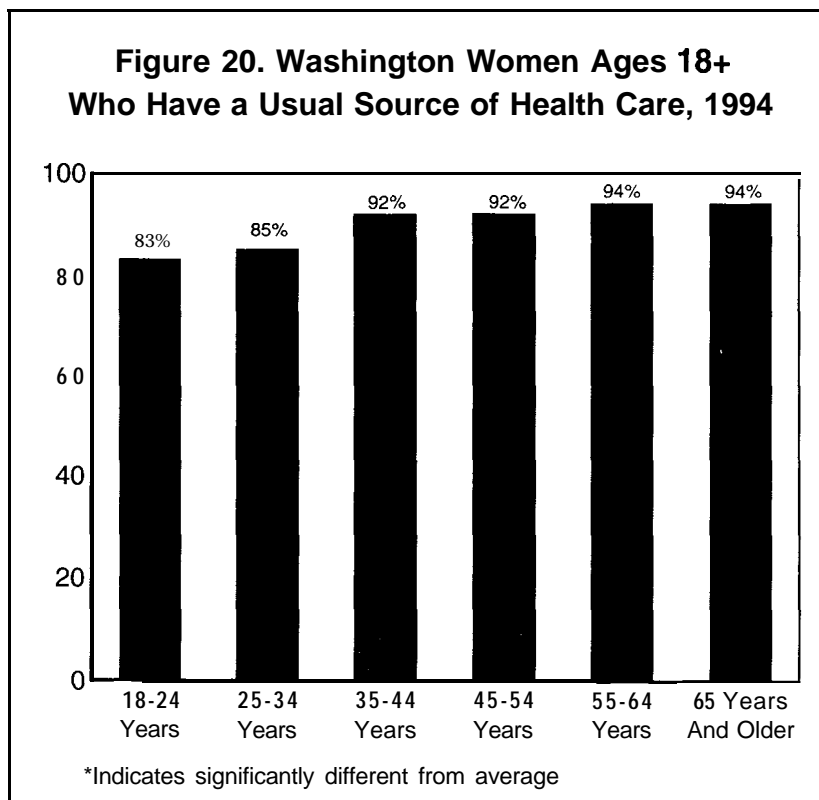
## Use of Preventive Services

Given what we know about women’s ability to access care, how did they use services that might help them stay healthy?

One way to measure this is to determine how many receive routine physical examinations, an important tool in detecting

and treating chronic diseases and other health threats.

Washington women are significantly more likely to have had a recent checkup than are men. In 1994, more than three-fourths of Washington women had had a checkup within the previous 12 months, compared with only 59% of Washington State men. More men than women had had a checkup within the past 1 to 2 years, however. Men were twice as likely as women to have had a last checkup 2 to 5 years earlier and about 2.5 times more likely than women to have had their last checkup more than 5 years ago.



Mammogram. Another important screening tool is mammography, which can detect breast cancer at earlier stages than it can be identified by self-examination. One estimate is that 93% of women whose breast cancer is detected in the early stages — something possible only with regularly scheduled mammography — will survive 5 or more years.<sup>3</sup> Washington State has a breast health program focusing on low-income women (<200% of the federal poverty level) age 40 and older, particularly those at highest risk, including women of Native American, African American, Hispanic, Southeast Asian origin, and lesbian women.

Until earlier this year, it was recommended that, in general, women ages 50 and older should have a mammogram and clinical breast examination every 2 years. Although the new recommendation is that mammography begin at 40, most targets and surveys are based on the behavior of women 50 and older. *Healthy People 2000* calls for a minimum of 60% of U.S. women ages 50 and older to have a mammogram every 1 to 2 years. In 1994, 62.1% of U.S. women ages 50 and older had had a mammogram and clinical breast examination in the past 2 years. In Washington State, the share is higher, at 69%. Use of mammography among Washington women drops steadily after age 59.

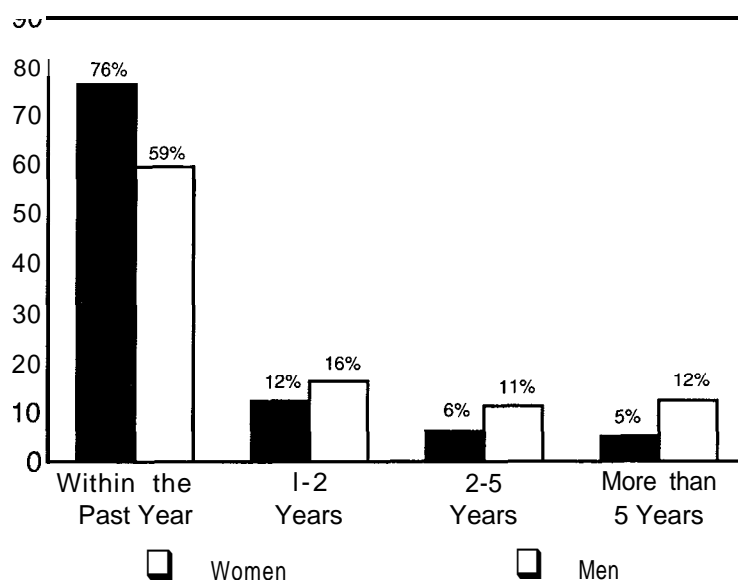
But the sharpest and most systematic difference in mammography use is seen when comparing Washington women ages 50 and older in terms of income. Only half of women ages 50 and older with annual incomes less than \$15,000 a year had had a mammogram, compared with 90% of women with incomes of \$50,000 or more.

The income difference in mammography use is mirrored in the difference by education: the lower the education level of women ages 50

*"I don't have insurance, so up front ... I explain what my income is and the amount that I can pay each month. When I finally found someone who gave me every attention that I needed . . . and was perfectly willing to take my monthly payment, ... it was oh...."*

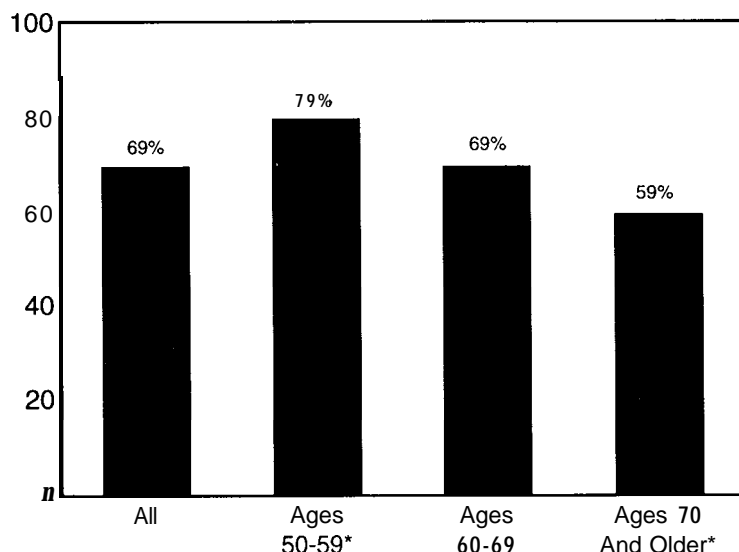
-focus group of Older Women in King County

**Figure 21. Washington Women and Men\*  
Time Since Last Checkup, Ages 18+, 1994**



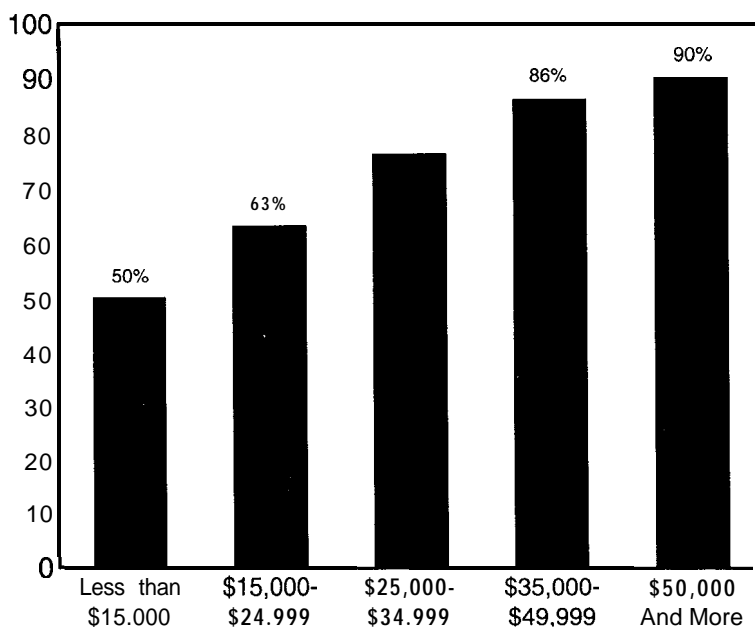
\*All gender differences significantly significant

**Figure 22. Washington Women, Ages 50+  
Having a Mammogram and Breast Exam  
In Last 2 Years, by Age, 1994**



\*Indicates significantly different from average

**Figure 23. Washington Women, Ages 50+  
Having a Mammogram and Breast Exam  
In Last 2 Years, by Income, 1994**



and older, the lower their use of mammography. Mammography rates are only 59% among the least educated women, those with less than a high school education. They rise to 63% among women with a high school education or GED and to 76% among women with some post-secondary education. Rates of mammography use among women with some post-high school education and those who completed college are the same, at 76%.

**Pap smears.** Another important screening examination for women is the Pap smear, a test for cervical cancer. It is currently recommended that all women with an intact uterus and no history of prior abnormal tests have a Pap smear at least every 3 years, and *Healthy People 2000* calls for at least 85% of women ages 18 and older to follow this regimen.

Statistically, this target has been met. An average of 84.9% of U.S. women ages 18 and older with intact uteri had Pap smears within the past 3 years. In Washington, 87.2% of women with intact uteri met this objective.

Pap smear use changes over the life course among Washington women: 85% of those age 18 to 24



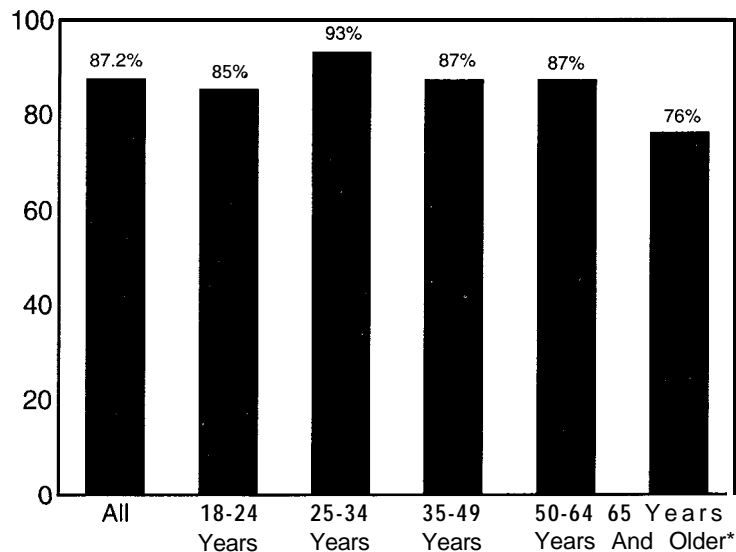
had a Pap smear in the last 3 years, as did 93% of women ages 25 to 34, but only 76% of women ages 65 years and older had timely Pap smears, a rate significantly below the Washington average. There is little variability in the rate of Pap smears among Washington women when compared by race.

There are marked disparities in the rate at which Washington women receive timely Pap smears when comparisons are made in terms of income and education. Women who live in households earning between \$10,000 and \$15,000 a year have significantly lower rates of Pap smear use than do Washington women over-all. In contrast, more than 90% of women living in households with incomes of \$35,000 or more had a Pap smear in the past 3 years.

Women who had less than a high school education also had far lower Pap smear rates (74%) than did women with some post-secondary education, (86% to 87%). The highest Pap smear rates, 92%, were seen among women who were college graduates.

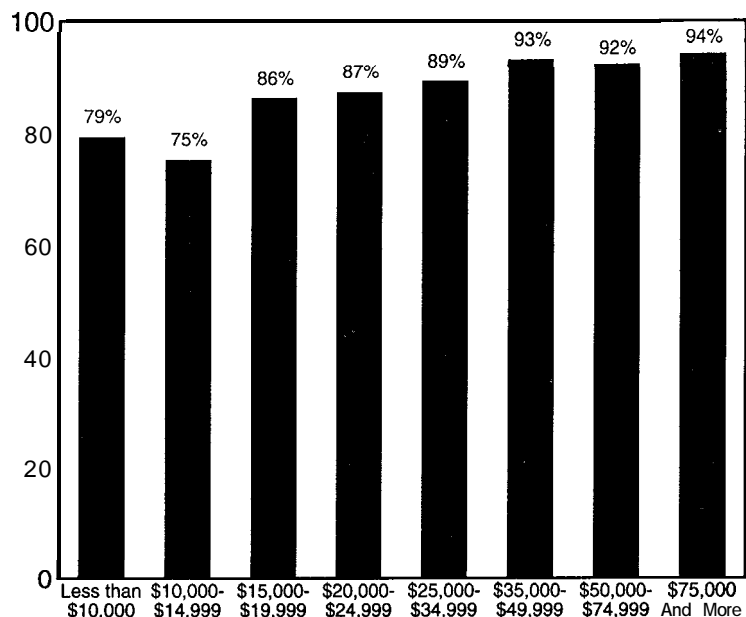
These figures help explain why Washington recently embarked on efforts to improve access to

**Figure 24. Washington Women With Intact Uteri, Having a Pap Smear In Last Two Years, by Age, 1994**



\*Indicates significantly different from average

**Figure 25. Washington Women With Intact Uteri, Having a Pap Smear In Last 2 Years, by Income, 1994**



*“I was a junior in high school and we have applied biochemistry and I was already pregnant. It was too late.”*

— focus group of DSHS clients in Pacific County

screening for cervical cancer. These efforts, coordinated through local health departments and other providers, are focused especially on low-income women ages 40 and older.

**Diabetes-related care.** Diabetes is a chronic condition often requiring careful management with combinations of diet, weight control, and medication. Persons with diabetes often use health services more than people without this condition. In 1994, Washington men with diabetes made an average of 4.4 office visits for diabetes treatment, compared with only 3.4 visits for Washington women. It may be that Washington women were better than men at managing their diabetes, but this disparity may also show that women encountered more barriers to accessing the care they needed.

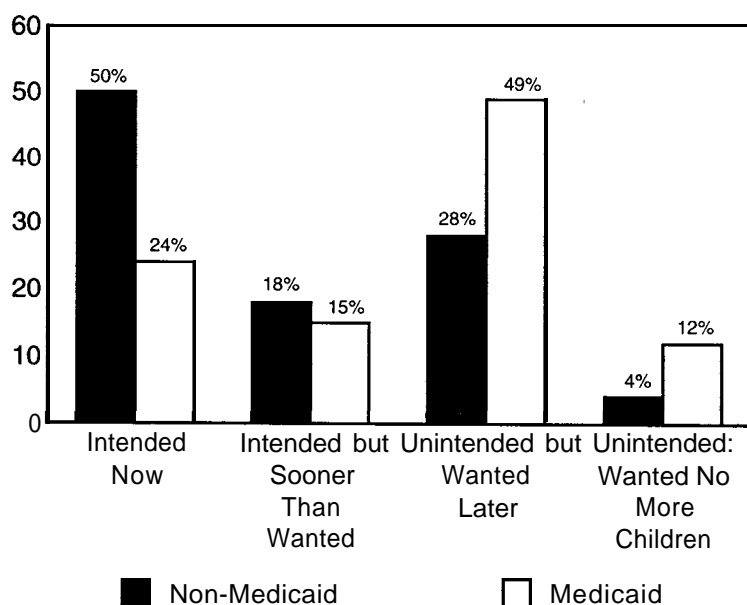
## Pregnancy

Among women of child-bearing age, generally defined as between ages 15 and 44, pregnancy creates a need for access to services, whether for abortion to terminate an unintended pregnancy or for prenatal care. One of the *Healthy People 2000* goals is to reduce unintended pregnancies to no

more than 30% of all pregnancies. A recent report estimates that nearly 60% of all pregnancies among U.S. women are unintended — that is, either the woman intended to have no more children when she became pregnant or she did not intend to become pregnant at that time but did intend to have more children later.<sup>4</sup> In Washington in 1993 and 1994, about 55% of all pregnancies and 40% of all births were unintended.<sup>5</sup>

In Washington, the Pregnancy Risk Assessment Monitoring System (PRAMS) surveyed a sample of women giving birth in 1993 and compared the “pregnancy intention” of

**Figure 26. Was Latest Birth Intended?  
Washington Mothers Delivering in 1993\***



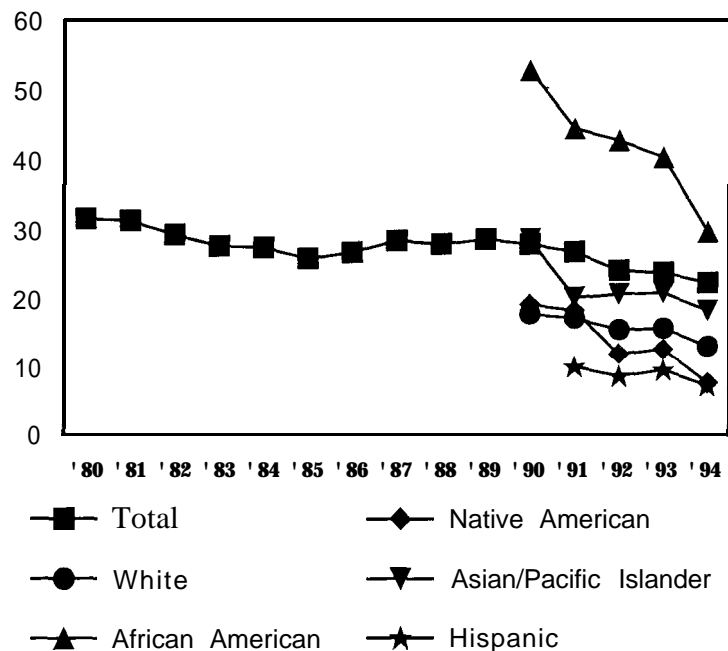
\*Washington State First Steps Database, September 1995

women whose deliveries were paid for by Medicaid with those whose deliveries were reimbursed using some other mechanism.<sup>6</sup> The study found systematic differences between women whose deliveries were reimbursed through Medicaid and other women. Those whose deliveries were financed by Medicaid were far less likely to have intended their most recent birth and more likely to have wanted no more children.

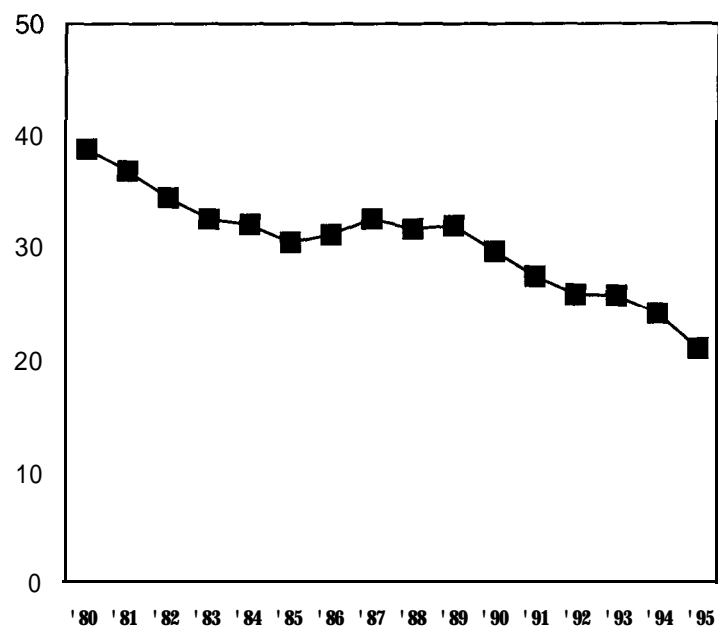
More insight about who can access reproductive services comes from the public use abortion and birth databases provided by the Washington State Department of Health Center for Health Statistics. Detailed race-by-gender-by-age population estimates are available for 1990 to 1994, so for those years, race-specific measures can also be calculated.

Abortion rates among Washington women have fallen steadily from 31.6 per 1,000 women ages 15 to 44 in 1980, to 20.7 in 1995. There are significant differences in abortion rates by race and ethnicity, but these rates should be used with caution because race was identified only in about two-thirds of cases. African American women have the highest abortion rates, which ranged from 52.8 per 1,000 women in 1990 to 29.7

**Figure 27. Abortions Per 1,000 Women  
Ages 15 to 44, Washington, 1980-95**



**Figure 28. Abortions per 1,000 Girls 15 to 17  
Washington, 1980-95**



*“Right now I am doing whatever the State gives me which is they have been helping me with prenatal care, providing a doctor for me, vitamins for me, the prenatal pills... They have been providing me a lot with the clothes and the necessary things for babies.”*

— focus group of Homeless Women

in 1994. These rates are significantly higher than those of other women, indicating that African American women have higher rates of unintended pregnancy, perhaps because of problems accessing culturally appropriate family planning services. Asian/Pacific Islander women had abortion rates ranging from 28.7 per 1,000 women ages 15 to 44 in 1990 to 18.4 in 1994. These rates, while significantly lower than those of African American women, are also significantly higher than those seen among women of other racial and ethnic backgrounds.

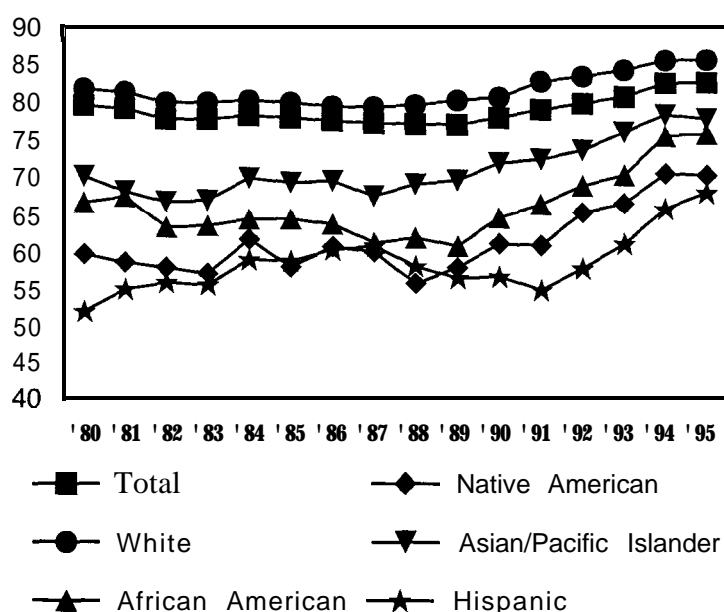
In the early 1990s, white women and Native American women had comparable abortion rates, 17.3 per 1,000 in 1991 for white women and 18.4 among Native American women. Since 1991, however, abortion rates among Native American women have fallen to the point where they are no different from those of Hispanic women, who have the lowest abortion rates of any group of women in Washington State.

Nationally, abortion rates are higher among teenagers than among all women ages 15 to 44. This was true in Washington in the early 1980s, when the rate among girls ages 15 to 17 was 38.7 per 1,000 compared with

31.6 for all women age 15 to 44. But by 1995, the rate had fallen to 20.9, essentially the same as the rate seen among all women, which is 20.7.

For women who are pregnant and intend to carry to term, prenatal care is an important component of having healthy babies. Through prenatal care, such health conditions and behaviors as high blood pressure or smoking, which threaten the pregnancy, can be identified and addressed. Because prenatal care is so important to pregnancy outcome, **Healthy People 2000** and the Washington State Public Health Improvement Plan both have objectives that

**Figure 29. Percent of Washington Mothers Beginning Prenatal Care In First Trimester, 1980 to 1995**



at least 90% of pregnant women should access prenatal care within the first 3 months of their pregnancy (the first trimester).

Nationally, considerable stagnation has occurred in the rate at which women access prenatal care; in 1993, only about 78% of women achieved this target. A similar pattern can be seen in Washington until the early 1990s; the rate was 79.5% in 1980, an all-time low of 77% in 1989, and 79% in 1991. Since then, however, the share of women getting first-trimester care has increased steadily. In 1995, the rate was 82.6%, significantly better than the 1980 rate. Part of this improvement may be attributed to expansions of Medicaid coverage to new groups of low-income pregnant women.

As was true with abortion rates, there are significant racial and ethnic differences in which women access prenatal care in their first trimesters of pregnancy. Before those differences are explored, it should be pointed out that between 1980 and 1995, the rate of first-trimester care improved significantly for African American, Native American, and Hispanic women.

Nonetheless, important and statistically significant differences exist between the proportion of white women receiving first-trimester care, typically 80% or better in recent years, and women of other racial and ethnic groups.

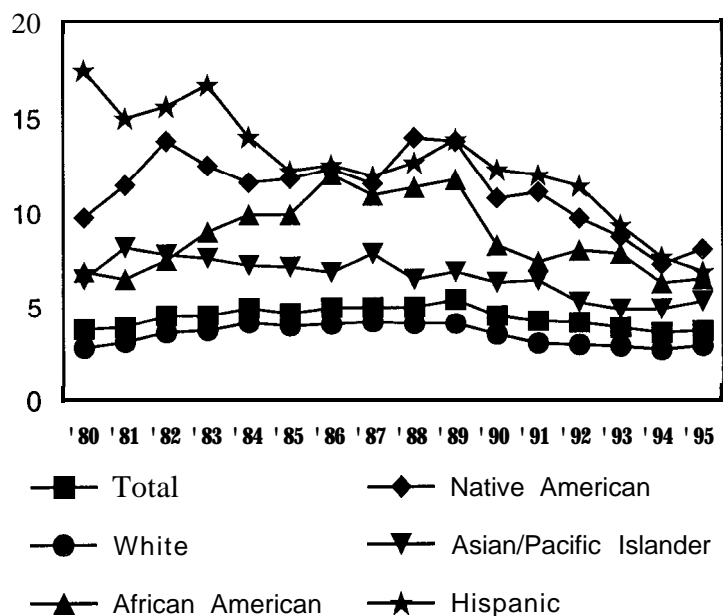
In recent years, about 75% of African American and 70% of Native American women received first-trimester care. More than three-fourths of Asian/Pacific Islander women also received first-trimester care. Despite recent improvements, Hispanic women persistently had the lowest rate of first-trimester care, less than 70%. This level is the same as that seen in Native American women, but significantly lower than that of other women.

What about women who

*"If I had insurance . . . I'm sure I would be treated a lot differently. I wouldn't have to sit for 6 hours with my sick children."*

— focus group of DSHS clients in Pacific County

**Figure 30. Percent of Washington Mothers Beginning Prenatal Care in Last Trimester Or Not at All, 1980 to 1995**



*"[My doctor] did not mention anything to do with sexuality. This is my annual and I haven't had one since high school and she did not say are you sexually active?"*  
-Lesbians focus group

don't begin care at the recommended time? In particular, how many of them delay until their third trimester or get no care at all? Several studies have indicated that, while it is highly desirable that women enter care in their first trimester, late or no care is the true risk factor for poor pregnancy outcomes. And when that measure is evaluated, the same patterns of improvement over time, coupled with significant racial differences, emerge.

The proportion of pregnant women in Washington receiving late or no prenatal care rose steadily from 3.8% in 1980 to 5.3% in 1989. Since then, there has been a steady reduction in this rate. In 1995, it was 3.5%, statistically no different from the 1980 rate.

Each racial and ethnic group experienced the same pattern of worsening then improving at least to the levels seen in 1980. White women had the lowest rates of late or no prenatal care, and the differences between their rates and those of each non-white racial ethnic group are always statistically significant. Until the early 1990s, Hispanic mothers were most likely to get late or no prenatal care: their rates fell from 17.5% in 1980 to 11.3% in 1992. But since then, there has been such dramatic reduction in this measure that their rates are now no different from those seen among non-white women. At least 1 in 10 Native American pregnant women had late or no prenatal care until 1993. Since that time, the share receiving late or no prenatal care has fallen to about 8%, a level statistically the same as that of African American or Asian/Pacific Islander women.

## Summary

The rate at which women have health care financing, their use of fundamental preventive health services, their access to reproductive health services, and whether their deliveries are intended appear to vary by income and by race. These patterns will continue to raise questions about the con-

figuration of our state and national health services delivery systems and about the general availability of culturally appropriate, affordable services.

## Notes

<sup>1</sup> The CDC recommends that when fewer than 500 respondents report a given behavioral factor, only rounded percentages be used. Inasmuch as only 182 men and 192 women respondents lacked insurance, the results were rounded.

<sup>2</sup> In the BRFSS survey, answers respondents give to questions are used to estimate what the rate of a given behavior would be for the entire adult population. This estimate has a range, usually called the 95% confidence interval: 95 times out of 100, the range includes the true rate for the population. If two rates have overlapping confidence intervals, they are not statistically different from each other. Confidence intervals for all rates in this chapter can be found in Technical Appendix A.

<sup>3</sup> Taber, L. *et al.* Reduction in mortality from breast cancer after mass screening with mammography. *Lancet* 1: 820-832, 1985.

<sup>4</sup> Institute of Medicine. *The Best of Intentions: Unintended pregnancy and the well-being of children and families*. National Academy Press: Washington, DC, 1995.

<sup>5</sup> *The Health of Washington State*. Olympia: Washington State Department of Health, September 1996, page 7.13.

<sup>6</sup> PRAMS is an ongoing population-based surveillance system sponsored by the CDC and implemented in Washington State by the Department of Health. PRAMS is designed to supplement vital records data and to generate state-specific data for planning and accessing perinatal health programs.



# Are Washington women living long and healthy lives?

- Reports of domestic violence are increasing in Washington. The rate of petitions asking for protection from domestic violence or harassment increased from 1992 to 1993, and the arrest rate for domestic violence increased significantly each year from 1988 to 1993.
- Rates of infection from three sexually transmitted diseases — pelvic inflammatory disease, gonorrhea, and syphilis — fell significantly among Washington women between 1991 and 1995, and they were lower than the national targets.
- The proportion of single women giving birth in Washington doubled from 13.6% of the total in 1980 to 26.9% in 1990.
- African American, Hispanic, and Native American mothers are more likely than white or Asian/Pacific Islander mothers to be young, single, and to have less than a high school education.
- Washington women generally have lower age-adjusted death rates from all causes than do men. In 1995, life expectancy was 79.7 years for women and 74.1 years for men.
- Age-adjusted death rates among Washington women for two tobacco-related causes of death, lung cancer and chronic obstructive pulmonary disease (COPD), rose nearly 50% from 1980 to 1995.
- Washington's female breast cancer death rate may not achieve either the national or the state Year 2000 target.
- Nearly 8 in 10 of the cervical cancer deaths in Washington occurred among women ages 45 and older, suggesting postmenopausal women may not be accessing Pap smears or getting treatment for abnormal results.





# Chapter 4. Health Status Indicators

This chapter contains information about five aspects of women's lives: domestic violence; sexually-transmitted diseases; birth-related indicators; osteoporosis; and patterns of mortality. It is based largely on a vital statistics database from the Washington State Department of Health Center for Health Statistics.

Washington women generally enjoy good health, as reflected in their life expectancy of nearly 80 years. This is only 1 or 2 years lower than the life expectancies of Japanese, Swiss, and French women, who have the highest in the world. Women in Washington also have lower death rates from both injuries and chronic diseases than do men. But the data in this chapter show two troubling trends. First, women's death rates from two tobacco-related causes, lung cancer and chronic obstructive pulmonary disease (COPD), rose by about half from 1980 to 1995. And second, minority women who give birth are more likely to be young, single, and poorly educated than their white counterparts. For African American women, these risks translate into elevated rates of low birthweight births and infant death.

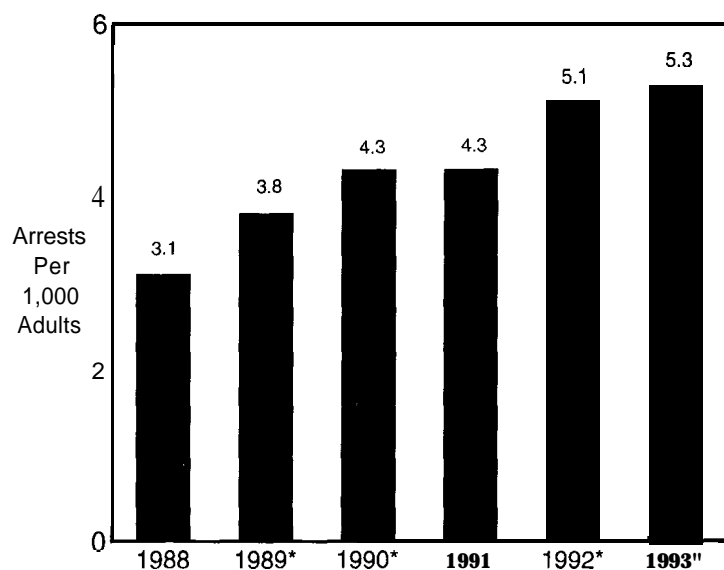
*"Win the lottery, the double one, and I would donate 75% of it to have a walk-in lesbian health clinic. This is what I would do."*  
— Lesbians focus group

## Domestic Violence

One of the major problems confronting women is that of physical and/or sexual abuse by their intimate partners. Perhaps as many as 30% of U.S. women will experience such abuse during their lives. While this proportion is higher than earlier estimates, the change does not necessarily mean that there were more cases, simply that more were reported.' As public awareness increases about domestic violence, reports tend to rise.

As part of a project to track youth violence indicators, the Washington Departments of Health and

**Figure 31. Washington Adults Arrested for Domestic Violence, Washington, 1988 to 1993**



\*Rates significantly different from previous years  
Data from Washington Youth Risk Assessment Database, June 1995

*“When you’re dealing with long-term issues like alcoholism and drug abuse in a family member, you need long-term support...”*

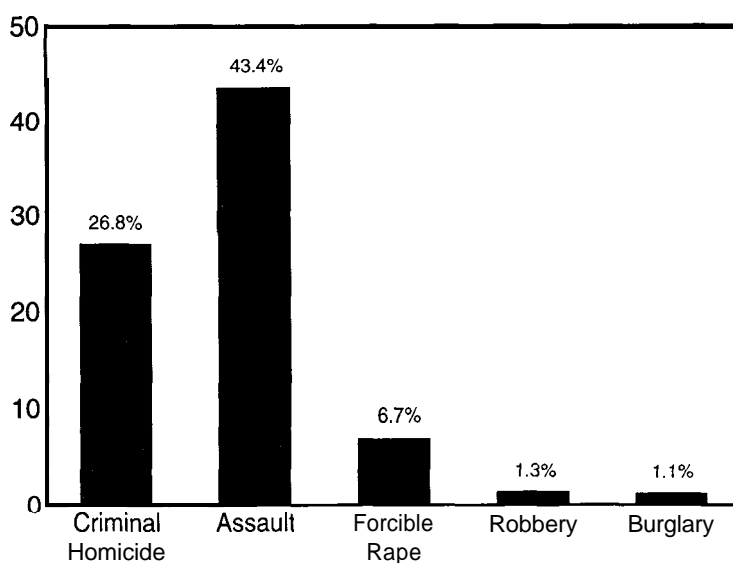
— focus group of DSHS clients in Pacific County

Social and Health Services monitors two measures of domestic violence: the rate at which petitions were filed for protection from both domestic violence and harassment; and the rate at which adults were arrested for domestic violence.<sup>2</sup> While gender-specific information is not available for these measures, studies in other settings have suggested that 80% of petitions filed for relief from domestic violence were by women, while about the same proportion of arrests occur among men.

In 1992, 26,646 petitions were filed in Washington State asking for protection from domestic violence or harassment; the rate was 5.2 per 1,000 persons. The next year, 29,282 petitions were filed, for a rate of 5.6 per 1,000. The more recent rate is statistically higher than the earlier one.

This same source provides information about Washington adults arrested for domestic violence between 1988 and 1993. The numbers point to statistically significant increases nearly every year from 1988 to 1995. Again, these increases may represent an absolute rise or may show that people are more willing to report domestic violence or to define an arrest as domestic violence.

**Figure 32. Violence-related Arrests**  
**Percent of Crimes that are Domestic Violence**  
**Washington, July to December, 1995**



Data from Washington Association of Sheriffs and Police Chiefs

A recent project of the Washington State Department of Health evaluated arrests for a 6-month period (July to December 1995) and attempted to determine how many arrests were related to domestic violence.

The estimate researchers developed showed that nearly half of all assaults and more than a fourth of all homicides were associated with domestic violence; these proportions represented 44 homicides and 19,175 assaults during the 6 months. Domestic violence was a far less frequent factor in forcible rapes, robbery, and burglary.

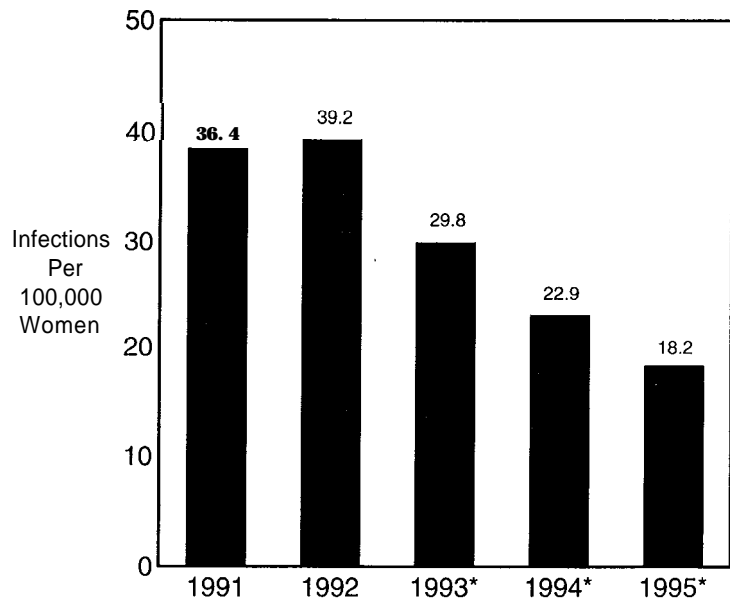
## Sexually transmitted Diseases

Health care providers are required to report many infectious diseases, some which are sexually transmitted, to public health agencies. It is widely believed, however, that many cases go unreported. Reports of sexually transmitted diseases for the 5 years between 1991 and 1995 were used to evaluate similarities and differences in disease rates among Washington women and men. Four diseases were assessed: pelvic inflammatory disease (PID); gonorrhea; chlamydia; and early syphilis.

PID, an inflammation of the reproductive organs that may lead to scarring, pelvic pain, infertility, and ectopic pregnancy, occurs only among women. A steady and, since 1993, statistically significant decline has occurred in PID rates among Washington women.

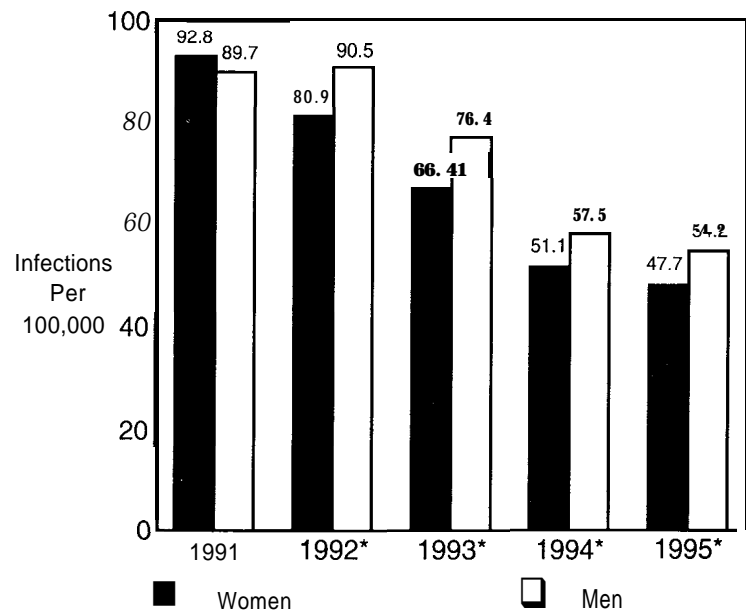
Gonorrhea rates in Washington have been significantly lower among women than men since 1992, perhaps because this disease is more symptomatic among men and so more likely to be diagnosed. Rates among Washington women and men in each year are far below the *Healthy People 2000* objective.

**Figure 33. Acute PID Infection  
Washington Women, 1991 to 1995**



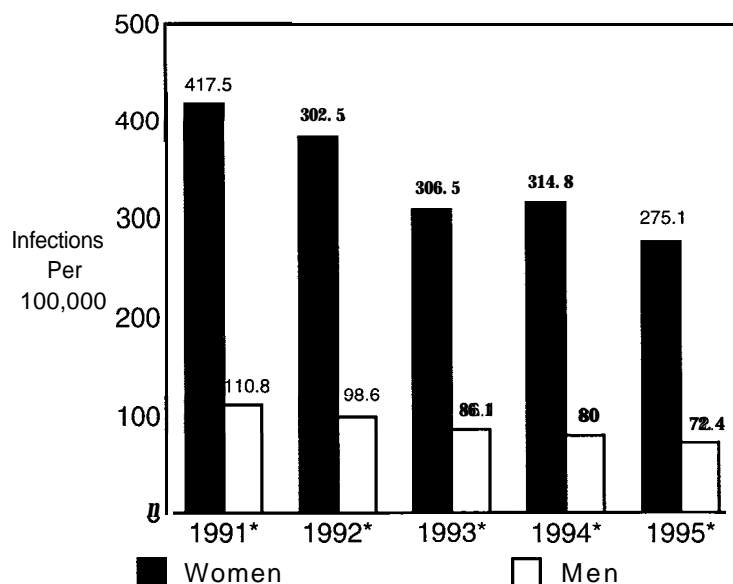
\*Statistically different from previous year

**Figure 34. Gonorrhea Infection  
Washington Women and Men, 1991 to 1995**



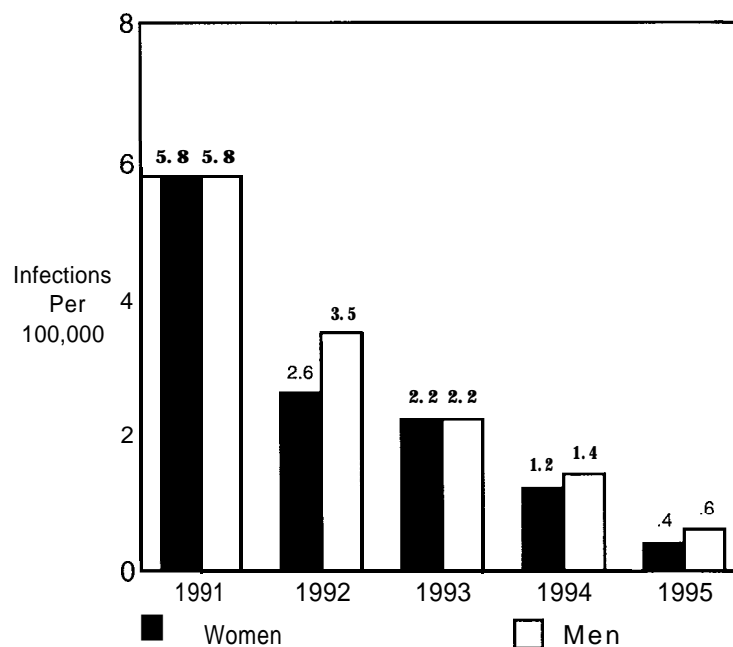
\*Gender differences are statistically significant.

**Figure 35. Chlamydia Infections  
Washington Men and Women, 1991 to 1995**



\*Gender differences are statistically significant.

**Figure 36. Early Syphilis Infections  
Washington Women and Men, 1991 to 1995**



Chlamydia infections show a different pattern: rates among Washington women are significantly greater than those observed among Washington men, perhaps because there is a screening project focused on women in family planning and Planned Parenthood clinics, STD clinics, and multiple community agencies across the state. Except in 1994, the gender-specific rates were significantly lower than the previous year's.

In common with other indicators of sexually transmitted diseases, the public health data show a steady decrease in early syphilis infections among Washington women and men. There is no significant difference in rates of early syphilis between women and men, but the secular decrease (the difference in rates over time) has been significant. As was true of gonorrhea, syphilis rates in Washington were far below the *Healthy People 2000* objectives.

## Birth-related Health Indicators

In evaluating pregnancy-related health indicators, we examine the racial and ethnic composition of mothers, their age, marital status,

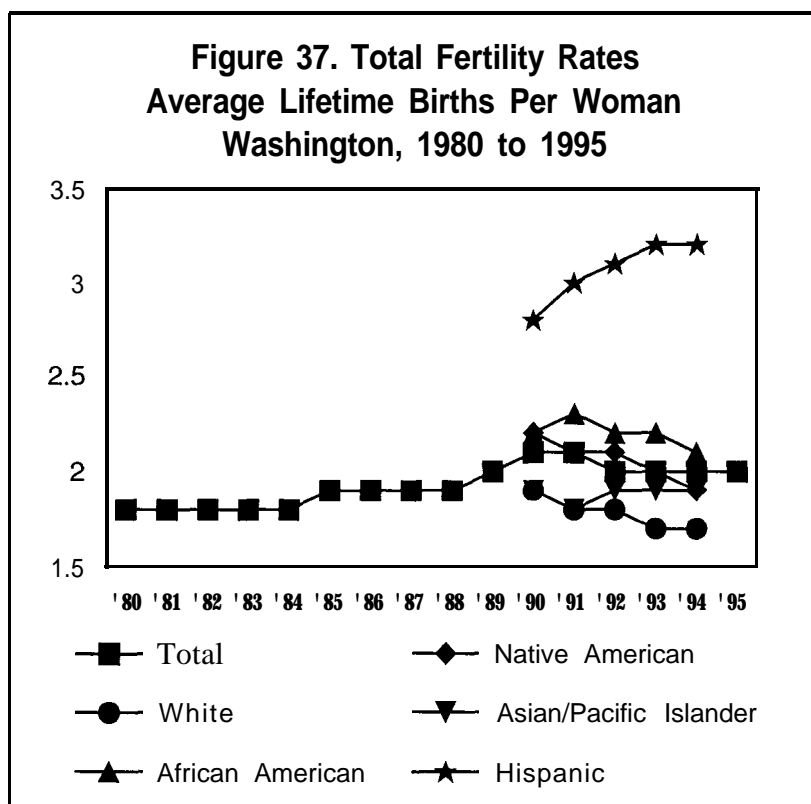
education, smoking, and pregnancy outcomes. The Washington State Public Health Improvement Plan (PHIP) and *Healthy People 2000* use these indicators. The race and ethnicity of mothers, the share that give birth when they are younger than 18, and their marital status and education are often used as proxy measures for socioeconomic disadvantage and indicate increased risk of poor pregnancy outcomes.

Much of the analysis in this section is derived from information that mothers provide for birth certificates.<sup>3</sup> For this analysis, we created a single measure of race and ethnicity; women were categorized as either white, African American, Native American, or Asian/Pacific Islander, four categories that exclude Hispanic women. Any women self-identifying as Hispanic is placed in that group, regardless of her racial identification. (See page 67 for important information about the quality of birth certificate data used in this section.<sup>4</sup>)

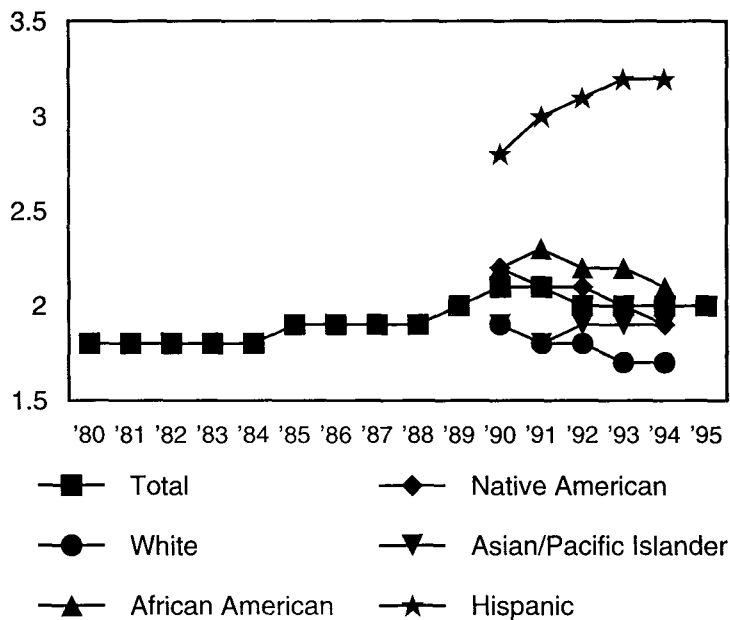
**Diversity.** One characteristic of Washington births from 1980 to 1995 has been the increasing diversity of mothers; in 1980, nearly 90% of women giving birth were white, but in 1995, that figure had fallen to 76.9%. The change reflects both the increasing diversity of women in the childbearing years and the tendency for some minority women to bear more children than do white women.

Births are best measured by the total fertility rate, an estimate of the number of children an average woman would have in her childbearing lifetime, which is defined as ages 15 to 44. A benchmark fertility rate is 2.1. At that level, each couple will replace itself. Rates greater than this imply population growth, unless high mortality rates offset the increase. Below-replacement fertility means, over the long

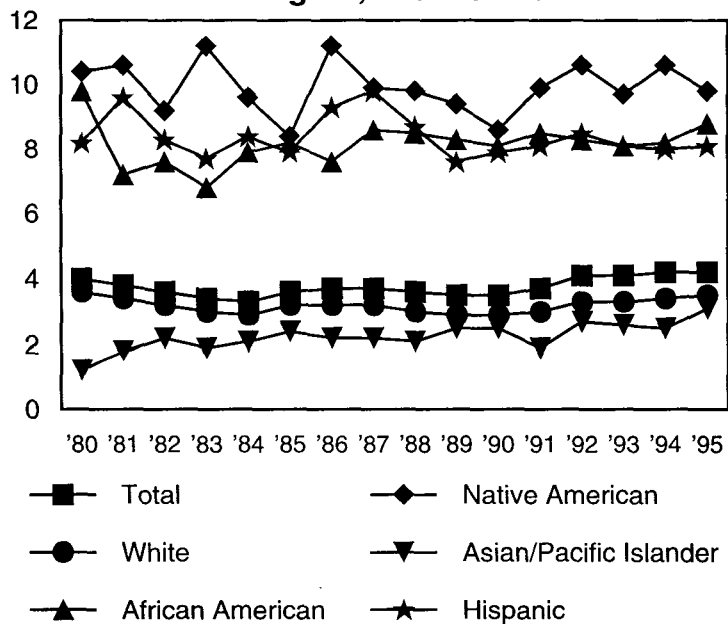
*"For example, if I have a cold, I don't know how to say what is cold, so I ask a friend who writes it in English and then write it down on the paper or I can find a nurse who will do the interpretation or the translation or a friend."*  
— focus group of Ethnic Chinese Women



**Figure 37. Total Fertility Rates  
Average Lifetime Births Per Woman  
Washington, 1980 to 1995**



**Figure 39. Teen Births by Race  
Percent of Births to Mothers Younger than 18  
Washington, 1980 to 1995**



run, that the share of a population that is young becomes smaller while that which is old becomes larger.

In Washington, the overall total fertility rate has been below replacement for all but 2 of the past 16 years. It is possible to compute race-specific total fertility rates for 1990 to 1994 only.<sup>5</sup> In this period, white women and women of Asian/Pacific Islander descent had similar total fertility rates, about 1.7 to 1.9, or below replacement level. Rates among African American and Native American women are generally higher than those of white and Asian/Pacific Islander women, and approximate replacement. In contrast, Hispanic women's total fertility rates have been increasing and are far above replacement.<sup>6</sup>

**Maternal Age.** In this section, we focus on births to girls age 15 to 17. Since the late 1960s, an ever-expanding body of literature has documented the substantial and often life-long negative consequences of childbearing for mothers younger than 18. More recent evidence suggests these disadvantages are found in their children as well.<sup>7</sup>

There are two national objectives regarding childbearing by school-age girls. One target is that the

rate of teenage pregnancy (both births and abortions to girls ages 15 to 17) not exceed 50 per 1,000 girls in that age group. The other is that the proportion of all births contributed by mothers younger than 18 not exceed 5%. The PHIP has a more demanding objective, a teen pregnancy rate of no more than 45 per 1,000. In 1995, the pregnancy rate among Washington teens ages 15 to 17 was 49.7.

The teen pregnancy rate has two components: births and abortions. The teen birth rate rose from 24.8 per 1,000 in 1980 to 32.9 in 1992. Since that time, it has fallen and was 28.8 in 1995. In contrast, there has been a steady reduction in the abortion rate, from 38.7 in 1980 to 20.9 in 1995.

In every year since 1980, Washington has met the goal that no more than 5% of births be to mothers younger than 18, but recent rates have been higher than earlier ones. In 1980, 4% of births were to girls younger than 18. The rate then fell to an all-time low of 3.5% in 1989 and 1990. Since then, it has been rising and reached 4.3% in 1995.

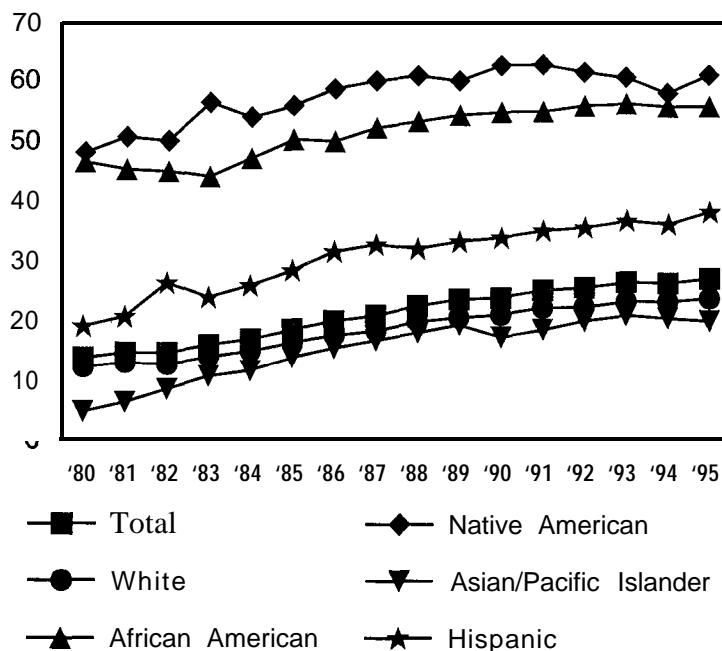
By 1995, more than 16% of Washington births to 15 to 17 year-olds were to Hispanic, Native American, or African American women, up from 6.6% in 1980. These groups have significantly higher teen pregnancy rates than do whites or Asian/Pacific Islanders. Thus to stop the upward trend in the share of births to school-age mothers, culturally sensitive efforts must be directed to young Hispanic, Native American, and African American women and their partners.

Another explanation for the rise in the proportion of births to the youngest mothers is that births among older women have also declined. This trend helps explain why the teen birth rate could come down while the proportion of births to which this age group contributes has risen.

*"Here at the clinic . . .  
there are classes  
and they show how  
to teach the children,  
when the children  
are 12, 13, and they  
are very good  
classes because  
they help us under-  
stand those kinds of  
problems and how to  
listen to the children  
and how to guide  
them..."*

-Hispanic Women  
in Toppenish focus  
group

**Figure 40. Percent of Births to Single Mothers  
By Race, Washington, 1980 to 1995**



*"I went to nursing school for a couple of years and then I quit because I didn't have enough financial aid for it . . ."*  
-focus group of Homeless Women

**Marital Status.** One of the significant demographic changes in the past 25 years has been the increasing proportion of women who are single when they give birth. Much research links female-headed families with poverty, which can often be intergenerational because children from female-headed families have a more difficult transition to adulthood than do children from married-couple families.<sup>8</sup>

There are two pathways to female-headed families: the mother may be unmarried when she gives birth; or she may be divorced at some point after giving birth. Research does not differentiate between these two pathways, so the true risk of giving birth as a single woman cannot be clearly defined. Moreover, the meaning of being single is unclear. The important question is whether the mother has support from significant others who are not her husband, such as a boyfriend, parents, or other relatives.

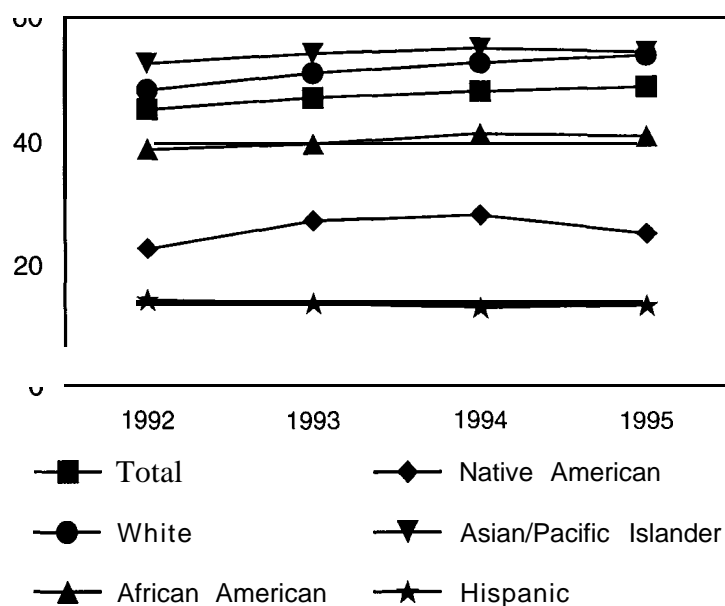
In Washington, the proportion of mothers who were single when they gave birth doubled, from 13.6% in 1980 to 26.9% in 1995. All racial and ethnic groups experienced statistically significant increases during 1980 to 1995. The largest increases were among white women, Hispanic women,

and Asian/Pacific Islander women. But the highest rates of single mothers are among Native American and African American women.

**Maternal Education.** Many studies have shown that, when health indicators are the outcome of interest, education is the best measure of socioeconomic status. Washington added a question about maternal education to the birth certificate beginning only in 1992, and the accuracy of this measure has not yet been assessed.

For this report, maternal education is defined as less than a high school education, a high school edu-

**Figure 41. Percent of Washington Mothers With More than a High School Education By Race, 1992 to 1995**





cation (including completion of a General Equivalency Diploma), or more than a high school education. Overall, two findings emerge. First, in the past 4 years, there have been significant increases in the proportion of mothers with less than and more than a high school education, and a corresponding drop in the proportion with a high school education. Second, at almost every educational level and in nearly every year, there are significant differences by race and ethnicity.

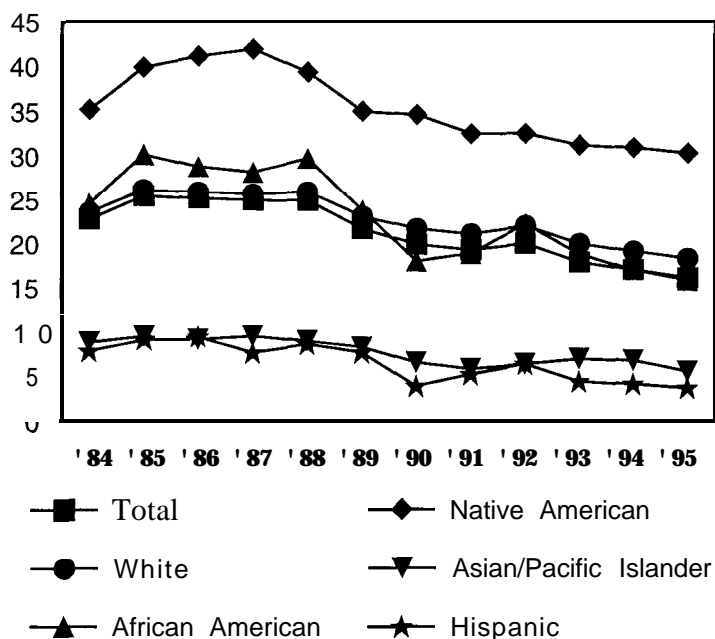
In 1992, 17.5% of Washington mothers had less than a high school education; 4 years later, that fraction had increased significantly, to 18.8%. Virtually all the increase can be explained by the significant rise in the number of Hispanic women with less than a high school education, from 61.5% in 1992 to 64.5% in 1995. These mothers were most likely not to have completed high school, followed by Native American mothers, then African American mothers, Asian/Pacific Islander mothers, and white mothers.

The proportion of Washington mothers with more than a high school education rose significantly, from 45.3% in 1992 to 48.8% in 1995. This change was driven by significant increases for white mothers. In 1995, white and Asian/Pacific mothers had the highest proportion with more than a high school education, 53.1% and 54.3%, respectively. Among African American mothers in 1995, 40.9% had more than a high school education compared with 25.1% of Native American mothers but only 13.4% of Hispanic mothers.

**Smoking in Pregnancy.** Regardless of socioeconomic status, there are behaviors in which a pregnant women can engage that increase the chances of her having a healthy baby. One of the most important of these is not smoking. Smoking is so important a factor in pregnancy out-

*"My husband smokes a lot and [my doctor] has been telling me . . . how to avoid being around places where he is and what to tell him to do. And I finally got him to stop smoking in the house, thank the good Lord."*  
— focus group of African American Women

**Figure 42. Percent of Washington Mothers Who Smoked During Pregnancy, 1980 to 1995**



*"It really bugs me that [my insurance plan] won't pay for a well-child check or annual exams or immunizations or mammograms. All those kinds of things that can save all kinds of health care dollars down the line."*

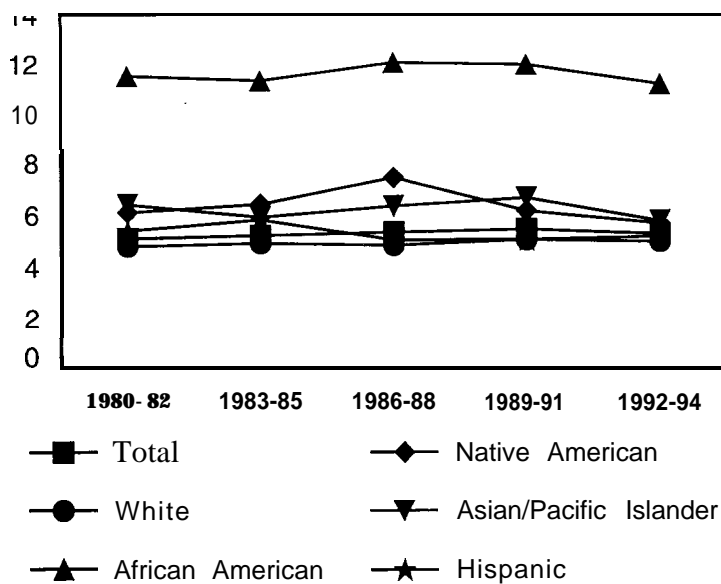
-focus group of African American Women

come that both *Healthy People 2000* and the PHIP have the objective that at least 90% of pregnant women refrain from smoking. It is widely believed that smoking is under-reported on birth certificates. While there has been a significant improvement over time, Washington women have not achieved this Year 2000 target. In 1984, 22.9% of pregnant women smoked, far above the target of 10% or less. By 1995, that share had fallen to 16.2%. The slow rate of decline makes it unlikely that the state and national target will be met.

Except for Native American mothers, all racial and ethnic groups have experienced significant decreases in their smoking levels. But there are significant differences in smoking by race. In 1995, Native American mothers were the most likely to smoke; 30.4% smoked. White mothers have the next highest rate of smoking, 18.1%, followed by 15.9% among African American mothers. The lowest smoking rates are found among Asian/Pacific Islander and Hispanic mothers, 5.5% and 3.7%, respectively.

**Pregnancy Outcomes.** Do the systematic differences in maternal age, marital status, and education by race and ethnicity foreshadow differences in pregnancy outcome? Two important measures of infant well-being,

**Figure 43. Percent of Washington Births Born Low Birthweight\*, by Maternal Race 1980 to 1982 through 1992 to 1994**



\*Weighing <2,500 grams at birth

low birthweight and infant mortality, are used to answer these questions. Both are rare events, so we use 3-year averages in our analyses. Low birthweight, or weighing less than 2,500 grams (about 5.5 pounds), is a major risk factor for infant death and for long-term disability among survivors. The *Healthy People 2000* goal is that no more than 5% of infants be low birthweight; the PHIP goal is no more than 4.2%. Washington women are not very close to achieving either target. From 1980 to 1982, 5.1% of babies born to Washington women were low birthweight, statistically the

same as the 1992 to 1994 rate of 5.2. Low birthweight rates were lowest among babies born to white, Native American, and Hispanic mothers. Infants born to African American women had a low birthweight rate of 11.1%, the highest of any group.

Infant mortality rates, the number of infants who die before their first birthday relative to the number of babies born (expressed as deaths per 1,000 births), have long been considered among the most sensitive indicators of general well-being. In fact, one of the earliest signals that the former Soviet Union was in trouble was a precipitous rise in infant mortality.

**Healthy People 2000** includes an objective that the infant mortality rate not exceed 7 deaths per 1,000 births; the PHIP sets a lower level, no more than 6.5. By 1992 to 1994, Washington appeared to have achieved even its more demanding objective; the infant mortality rate in that period was 6.1, down significantly from 10.6 in 1980 to 1982.<sup>9</sup> Every racial and ethnic group had infant mortality rates in 1992 to 1994 that were significantly less than the 1980 to 1982 rates. Yet, despite this widespread improvement, significant differences in race-specific rates persisted.

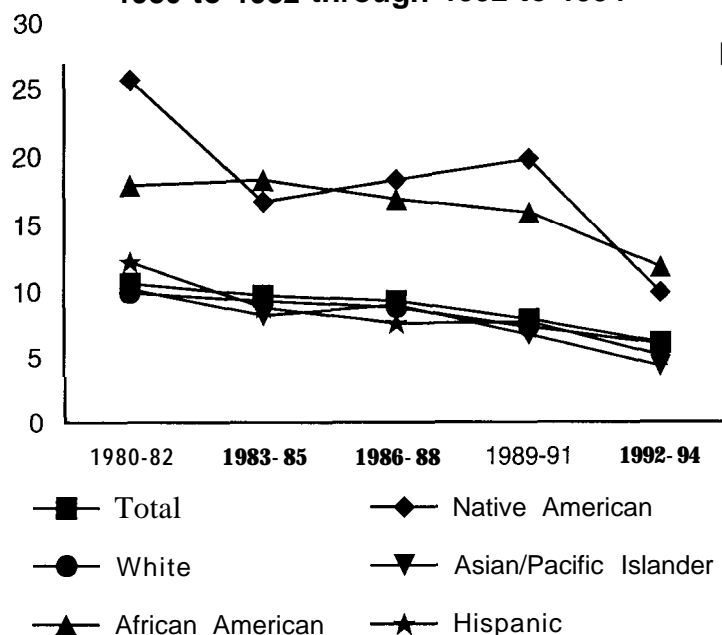
The lowest infant death rate, 4.3 deaths per 1,000 births, was among infants born to Asian/Pacific Islander women. Babies born to white and Hispanic women had similar death rates, 6 and 5.1, respectively. The highest infant death rates were among Native American and African American infants, 9.9 and 11.8, respectively.

## Osteoporosis

Although osteoporosis can affect both women and men, it is now recognized as one of the most common and serious problems facing

*"I had a child with a life-threatening illness. What I discovered was that everyone in town knew it. The entire community rallied within a day."*  
— focus group of DSHS clients in Pacific County

**Figure 44. Washington Infant Mortality Rate  
Deaths per 1,000 Births, by Maternal Race,  
1980 to 1982 through 1992 to 1994**



*"I wouldn't be in this shape now if I'd had the openness and the freedom to take the advice of other doctors, not just a family practice MD, who doesn't have time for anything but tonsils and hysterectomies."*  
— focus group of Older Women in King County

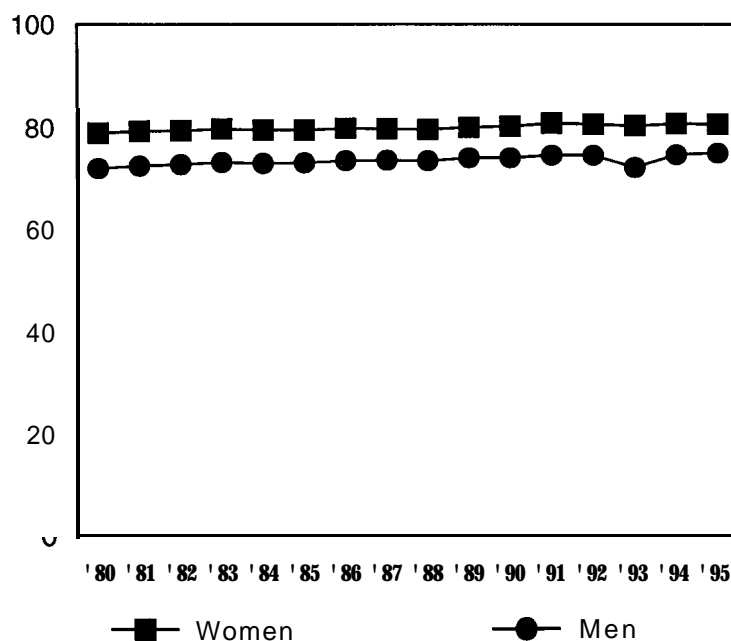
postmenopausal women. It can cause loss of physical mobility, independence, and increased health care costs. Data about osteoporosis are scarce because it is not readily diagnosed, and there are no reporting requirements.

Hip fracture is one of the most disabling conditions associated with osteoporosis. People hospitalized with hip fractures are only a portion of those who have osteoporosis, but we can use hospital discharge summary data to evaluate this aspect of the disease. These data show that, in 1994, hip fractures in Washington resulted in hospitalizations of 1,087 males and 3,417 females.<sup>10</sup> Hospitalization rates in women, 956 per 100,000, were more than twice those of men, 418 per 100,000. The hospitalization rate for hip fractures among all persons 65 and older was 729 per 100,000, far above the Washington State PHIP target of 63.1. Women are more likely than men to be hospitalized for hip fractures. Age-specific hospitalization rates among women ages 50 and older are nearly twice those of men the same ages.

## Patterns of Mortality

A good summary indicator of health in any given population is life

**Figure 45. Life Expectancy for Women and Men  
Washington, 1980 to 1995**



expectancy, or the number of years a person born today could expect to live, given current mortality rates. Life expectancy has been steadily rising in the United States. In 1994, it was 75.7 years, 79 years for women and 72.4 years for men. Whites consistently have the highest life expectancy: 76.5 in 1994 (79.6 for women, 73.3 for men). African Americans have the lowest: 69.5 in 1994 (73.9 for women, 64.9 for men). In 1980, Washington women could expect to live 79 years; by 1995, they could expect to live 80.7 years. Men here had a life expectancy of 72.1 in 1980 and 75.1 in 1995.

## Leading Causes of Death

On the following two pages, we present data showing the leading causes of death among Washington women and men over a 3-year period from 1993-95.<sup>11</sup> We begin by showing the causes of death for all ages. As the risk of death varies greatly by age, we then group and rank the causes for different age groups: children and adolescents ages 1 to 14; young people ages 15 to 24; three groups of adults (ages 25 to 34, 35 to 44, and 45 to 64);

*“What worries me is that I’m 64 for now, next year I’ll be 65 and I’m wondering will I get the health care that I’m getting now?”*  
— focus group of African American Women

**Figure 46. Leading Causes of Death, Washington, 1993-95<sup>12</sup>**

### All Washington Women and Men

Cause	Women	Men
Ischemic heart disease	1) 16.5%	1) 18.9%
Other heart disease	2) 11.7%	3) 9.7%
Other cancers	3) 11.4%	2) 14%
Stroke	4) 10%	5) 6.1%
Lung cancer	5) 6.3%	4) 8.5%
Chronic obstructive pulmonary disease (COPD)	6) 5.5%	7) 5.5%
Pneumonia/influenza	7) 4.4%	8) 3.3%
Breast cancer	8) 4%	
Diabetes	9) 2.8%	10) 2.3%
Unintended injuries	9) 2.8%	6) 5.7%
Colorectal cancer		9) 2.4%

### Girls and Boys Ages 1 to 14

Cause	Girls	Boys
Motor vehicle injuries	1) 20.1%	1) 16%
Other unintended injuries	2) 16.6%	2) 24.7%
Cancer	3) 14.5%	3) 11.7%
Homicide	4) 9.8%	5) 7.2%
Birth defects	5) 8.6%	4) 9.9%

### Young People Ages 15 to 24

Cause	Women	Men
Motor vehicle injuries	1) 31.8%	1) 30.3%
Homicide	2) 13.7%	3) 15.9%
Suicide	3) 12%	2) 20.6%
Cancer	4) 9%	5) 5.3%
Other unintended injuries	5) 7.4%	4) 14.1%

*“With my mother and with my children and with my grandmother we didn’t acknowledge hurt and we didn’t acknowledge pain.”*

— Women of the Colville Indian Tribe focus group

#### **Women and Men Ages 25 to 34**

	<b>Women</b>	<b>Men</b>
Motor vehicle injuries	1) 16.4%	4) 13.6%
Cancer	2) 15.8%	
Suicide	3) 12.2%	2) 17.7%
Other unintended injuries	4) 8.7%	3) 15.3%
Homicide	5) 8.5%	5) 8%
HIV infection		1) 21.4%

#### **Women and Men Ages 35 to 44**

<b>Cause</b>	<b>Women</b>	<b>Men</b>
Other cancer	1) 22.3%	
Breast cancer	2) 12.1%	
Heart disease	3) 9.1%	3) 12.3%
Other unintended injuries	4) 6.5%	2) 13.2%
Motor vehicle injuries	5) 6.3%	5) 6.8%
HIV infection		1) 20.7%
Suicide		4) 10.1%

#### **Women and Men Ages 45 to 64**

<b>Cause</b>	<b>Women</b>	<b>Men</b>
Other cancer	1) 23.4%	2) 20.6%
Heart disease	2) 15.9%	1) 29.6%
Lung cancer	3) 13.4%	3) 12.3%
Breast cancer	4) 10.6%	
COPD	5) 5.3%	5) 3.5%
Unintended injuries		4) 5.4%
Stroke		5) 3.5%

#### **Women and Men Ages 65 to 74**

<b>Cause</b>	<b>Women</b>	<b>Men</b>
Other cancer	1) 25%	2) 20.5%
Ischemic heart disease	2) 14.8%	1) 21.6%
Lung cancer	3) 12.9%	3) 14%
COPD	4) 9.1%	5) 7.3%
Other heart disease	5) 8.7%	4) 9.6%

#### **Women and Men Ages 75 and Older**

<b>Cause</b>	<b>Women</b>	<b>Men</b>
Ischemic heart disease	1) 19.7%	1) 22.1%
Cancer	2) 16.2%	1) 22.1%
Other heart disease	3) 14.4%	3) 11.2%
Stroke	4) 12.8%	4) 9.1%
Pneumonia/influenza	5) 5.9%	
COPD		5) 7%

and other adults ages 65 to 74 and 75 and older.

(In this section of the report, data are limited to comparisons between males and females and not additionally by racial and ethnic origin. This is because death certificates, unlike birth certificates, have a substantial amount of racial misclassification.)

## Age-adjusted Death Rates

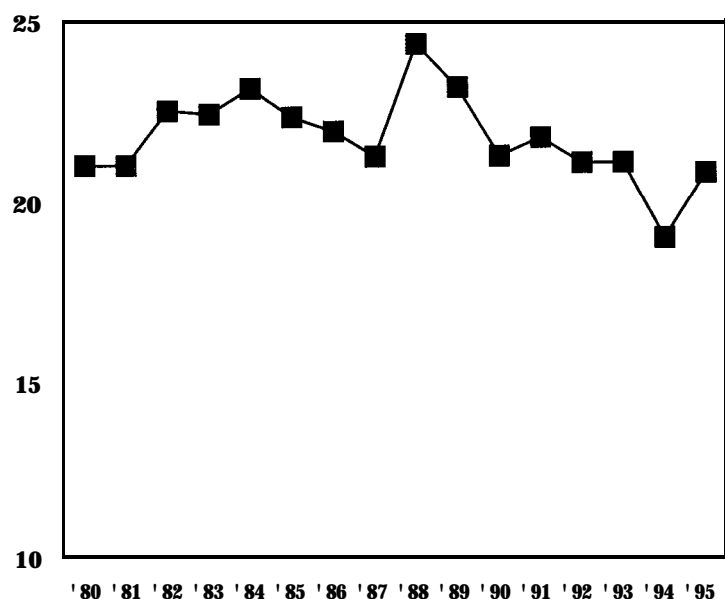
A statistical technique called age-adjustment results in death rates that reflect what might occur if every population had the identical age structure. One national target is that the age-adjusted death rates for all causes not exceed 500 deaths per 100,000 people. In Washington, age-adjusted death rates fell between 1980 and 1995, but the decline was greater for men than women. In 1980, men had a death rate of 692.3, and in 1995, it had fallen to 555.9, while rates among females fell from 402.3 in 1980 to 351.2 in 1995.

For this report, death rates for unintended injuries and their largest subset, motor vehicle injuries, were computed for 1980 through 1995, as were homicide and suicide rates. In addition, trends were plotted for coronary heart disease, stroke, all cancers, colorectal cancer, and cirrhosis. For each of these causes, rates observed among women are lower than those of men and have been either stable or are declining. More importantly, the recent rates are at or below the national and state targets. Detailed tables can be found in the technical appendix to this report.

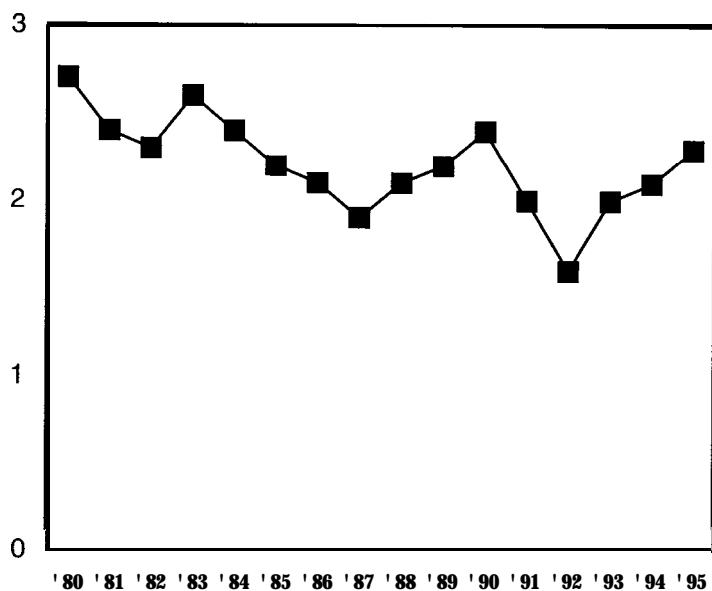
The findings with regard to four other causes of death differ, however: female breast cancer; cervical cancer; lung cancer; and

*"I have an ongoing problem. I'm a non-insulin-dependent diabetic and it costs about \$50 a month for glucose test strips. We get no help at all for that and we have no hope of getting."*  
— focus group of Older Women in King County

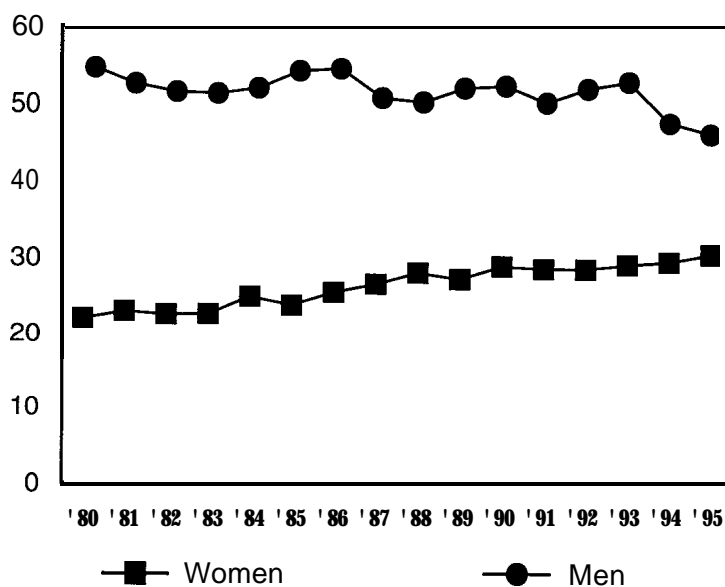
**Figure 47. Age-adjusted Death Rates  
Deaths per 100,000 Women  
From Breast Cancer, Washington, 1980 to 1995**



**Figure 48. Age-adjusted Death Rates  
Deaths per 100,000 Women from  
Cervical Cancer, Washington, 1980 to 1995**



**Figure 49. Age-adjusted Death Rates  
Deaths per 100,000 Women and Men  
From Lung Cancer, Washington, 1980 to 1995**



COPD. The national target for female breast cancer is an age-adjusted death rate of no more than 20.6 per 100,000 women.<sup>13</sup> The PHIP sets a more demanding target: no more than 18.9 per 100,000. Between 1980 and 1995, the death rate among Washington women from breast cancer was above the national target for all but 2 years, 1994 and 1995. Only in 1994 was the rate at the state target.

**Healthy People 2000** calls for the cervical cancer death rate to be no more than 1.3 deaths per 100,000 women; the PHIP sets a slightly higher target, 1.6 per 100,000. Washington women achieved the higher state target only once in the 16 years between 1980 and 1995, in 1992, and they never achieved the national target. Two aspects of these deaths are troubling. First, it is generally estimated that between 75% and 95% of all cervical cancer deaths are detectable and treatable with regular Pap smears. In other words, many of these women did not have to die. Second, the age distribution of women who are dying from cervical cancer raises questions about whether postmenopausal women and their health care providers know and are following recommendations that all women receive regular Pap smear tests from the



age when they become sexually active until they are 75.

Finally, death rates from two tobacco-related causes of death, lung cancer and COPD, have risen dramatically among Washington women, a trend particularly striking because there is no parallel change in rates for men. In 1980, the age-adjusted death rate among Washington men from lung cancer was 54.6 deaths per 100,000, while among women, it was 21.9, or 40% of the male rate. By 1995, the female rate was 30.7 and the male rate, 46.5.

A similar pattern characterizes COPD death rates. In 1980, the death rate for Washington males was 29.1, and in 1995, it was 27.5. But the female death rate rose from 13.3 in 1980 to 19.8 in 1995, a magnitude of increase essentially the same as that seen for lung cancer deaths.

Lung cancer and COPD death rates reflect increased cigarette smoking among women dating from the 1960s. Reversing the trend will require aggressive smoking cessation efforts aimed at all women, starting when they are young. Recent research also suggests that reducing smoking rates may also help reduce cervical cancer mortality. Reducing tobacco use among Washington women is one strategy that could raise life expectancy to levels seen in the healthiest industrial societies.

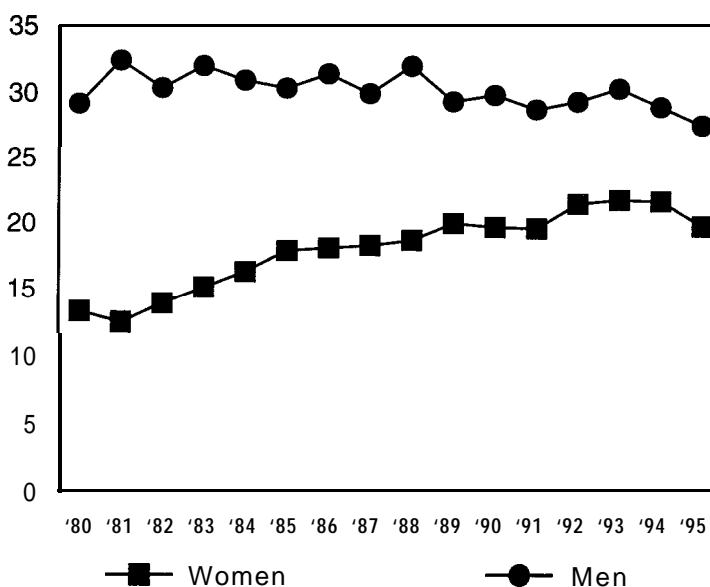
## Oral-pharynx Cancer

Health status indicators that assess dental health are difficult to obtain. One important measure of oral health is oral-pharynx cancer death rates. About three-fourths are associated with tobacco and alcohol use, and many can be detected early.<sup>14</sup> Regular dental checkups facilitate early detection.

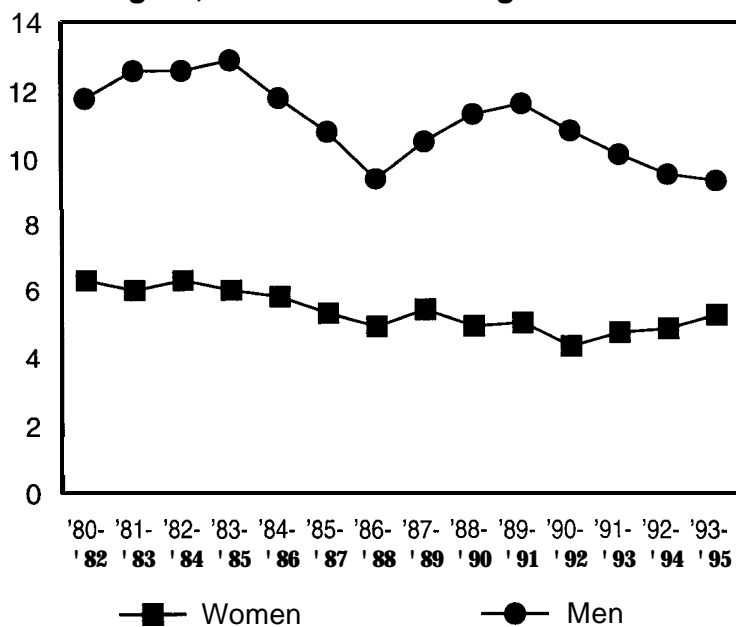
In any 1 year, the number of

*“Cancer runs in our family All my sisters, my mother, and myself have had a hysterectomy . . .”*  
— Women of the Colville Indian Tribe focus group

**Figure 50. Age-adjusted Death Rates  
Deaths per 100,000 Women and Men  
From COPD, Washington, 1980 to 1995**



**Figure 51. Oral-pharynx Cancer Deaths  
Per 100,000 Women and Men, Ages 45 to 74  
Washington, 1980 to 1982 through 1993 to 1995**



deaths from oral-pharynx cancer is small relative to other causes. For this reason, 3-year rates are shown. Among both Washington women and men, deaths rates have been falling. The risk of oral-pharynx cancer varies by gender. For this reason, **Healthy People 2000** sets one objective for women (no more than 4.1 deaths per 100,000 women ages 45 to 74) and another for men (no more than 10.5 per 100,000 men in this age group). Relative to these targets, Washington women fare worse than do men. The 1993 to 1995 rate among women was 5.2, nearly 25% greater than the national target. The rate

among men, 9.3, was below the national target. In no period between 1980 to 1982 and 1993 to 1995 did Washington women achieve the national objective for this indicator.

## Summary

**Healthy People 2000** was developed to achieve three goals: to increase our span of healthy life; to reduce health disparities; and to assure access to preventive services. By those standards, Washington women could do better. Life expectancy is still 1 to 2 years lower than the life expectancies seen among Japanese, Swiss, and French women. High death rates from tobacco-related illnesses contribute to this difference.

Troubling health disparities exist between racial and ethnic groups, at least when birth-related information is analyzed. Mortality rates from cervical cancer and the concentration of deaths among postmenopausal women suggest that many women may face barriers to accessing preventive services.

## Notes

<sup>1</sup> Strauss, M.A., and Gelles, R.J. Societal change and change in family violence from 1975 to 1985 as revealed in two national surveys. *Journal of Marriage and the Family* 48: 465-479, 1986.

<sup>2</sup> Youth Risk Assessment Database: A comprehensive report. Washington State Department of Health, Office of Epidemiology, and Washington State Department of Social and Health Services, Office of Research and Data Analysis. June, 1995.

<sup>3</sup> Information derived from birth certificates reflects information as provided by the mother and so is subject to the same limitations as any other self-reported data, such as that from the Behavioral Risk Factor Surveillance System. The quality of many items has been assessed by the Washington State Department of Health Center for Health Statistics. Birth data quality technical notes, September 1996.

<sup>4</sup> The coding of non-Hispanic races has been unchanged since 1980. In 1989, however, three new items on the Washington State birth certificate asked whether the mother, father, or baby was Hispanic. Asking specifically about Hispanic origin may have increased the proportions since this time.

<sup>5</sup> Computing a total fertility rate requires both age-specific births and population counts of women in 5-year age groups beginning at 15 to 19 and ending at 40 to 44. These population counts are available for distinct racial and ethnic groups from the Washington State Office of Financial Management for 1990 through 1994.

<sup>6</sup> The total fertility rate of Washington State Hispanic women in 1994 was approximately the same as that of Mexican women in the same year. However, the State's rate may not be accurate. If the population is undercounted, the resulting rate will be too high. If, as several writers have suggested, there was a substantial under-enumeration of Hispanic residents in the 1990 census, then the projections forward from that census would also be too low.

<sup>7</sup> Hayes, Cheryl D., editor. *Risking the Future: Adolescent Sexuality, Pregnancy, and Childbearing*. Washington DC: National Academy Press, 1987.

<sup>8</sup> Furstenberg, Frank F., Jr., and Cherlin, Andrew J. *Divided Families*. Cambridge MA: Harvard University Press, 1991.

<sup>9</sup> This rate may not be strictly comparable with reports published by the Washington State Department of Health because it was computed based only on infant death certificates and birth certificates where the infants' and mothers' race could be determined.

<sup>10</sup> *Osteoporosis: Public Health Strategies for Education, Prevention, and Treatment*: Olympia. Washington State Department of Health, May, 1997.

<sup>11</sup> Mortality experience in any 1 year may reflect unique circumstances, especially when comparisons are made among relatively small numbers of people, such as women of color. For that reason, 3 years' data were used in the calculations described here.

<sup>12</sup> Lung, breast, and colorectal cancers are evaluated separately from cancers in other sites because special emphasis has been given to prevention and early detection of these three.

<sup>13</sup> Age-adjusted death rates are computed using a standard population. The CDC and NCHS use the 1940 population as the standard, while the National Cancer Institute uses the 1970 population. The cancer targets and the death rates use the 1940 standard, consistent with *Healthy People 2000*.

<sup>14</sup> Blot, WJ, McLaughlin, JK, Winn, DM, *et al.* Smoking and drinking in relation to oral and pharyngeal cancer. *Cancer Research* 48: 3282-3287, 1988.



# Technical Appendix





# Chapter 1 Sociodemographics

## Washington State Population, 1995

Age Group	Women	Men
0-4	201,302	211,108
5-9	206,393	217,300
10-14	196,833	207,392
15-19	174,162	185,315
20-24	167,289	178,136
25-29	187,572	196,703
30-34	228,562	230,295
35-39	241,271	243,500
40-44	222,153	227,152
45-49	192,037	191,286
50-54	143,678	146,742
55-59	108,571	108,793
60-64	96,899	91,800
65-69	96,237	84,292
70-74	93,896	74,989
75-79	71,831	53,199
80-84	52,553	32,307
85+	48,260	20,092
Total	2,729,499	2,700,401

## Washington State Population, 1980

Age Group	Women	Men
0-4	149,444	<b>156, 679</b>
5-9	144,569	<b>151, 442</b>
10-14	156,835	<b>165, 160</b>
15-19	179,691	<b>189, 332</b>
20-24	194,284	<b>206, 258</b>
25-29	192,744	<b>197, 253</b>
30-34	175,892.	<b>178, 753</b>
35-39	134,667	<b>138, 715</b>
40-44	105,382	<b>108, 450</b>
45-49	96,068	<b>97, 405</b>
50-54	101,095	<b>97, 453</b>
55-59	105,663	<b>98, 323</b>
60-64	92,497	<b>86, 540</b>
65-69	81,029	<b>70, 295</b>
70-74	62,548	<b>49, 475</b>
75-79	46,410	<b>30, 999</b>
80-84	32,224	<b>17, 106</b>
85 +	28,807	<b>12, 669</b>
Total	2,079,849	2,052,307

**Washington Women By Age, 1995**

<b>Age Group (report Figure 1)</b>	<b>Percent</b>	<b>Number</b>
<5 years old	7.4%	201,302
5-17 years old	18.7%	511,519
18-24	8.5%	233,158
25-44	32.2%	879,558
45-64	19.8%	541,185
65-74	7.0%	190,133
75+	6.3%	172,644
Total		2,729,499

**Median Age of All Washington Men and Women, 1980 to 1995**

<b>Year</b>	<b>Women</b>	<b>Men</b>
1980	30.6	29
1981	30.9	29.2
1982	31.2	29.6
1983	31.7	30
1984	32.1	30.4
1985	32.5	30.7
1986	32.8	31.1
1987	33.1	31.4
1988	33.4	31.7
1989	33.6	31.9
1990	33.8	32.1
1991	34.0	32.4
1992	34.2	32.6
1993	34.5	32.8
1994	34.7	33.1
1995	35.1	33.3

**Racial Composition of Washington Women, 1994  
(report Figure 2)**

<b>Race</b>	<b>Percent</b>	<b>Number</b>
White	89.3%	2,398,721
African American	3.1%	83,916
Native American	1.9%	50,301
Asian/Pacific Islander	5.7%	154,290
Total		2,687,228

**Washington Women By Ethnicity, 1994**

<b>Ethnicity</b>	<b>Percent</b>	<b>Number</b>
Hispanic Origin	4.9%	132,848
Not Hispanic	95.1%	2,554,380



**Age Composition of White Washington Women, 1994**

<b>Age Group</b>	<b>Percent</b>	<b>Number</b>
<5 Years Old	7.2%	172,147
5-19	20.1%	480,983
20-24	6.3%	151,162
25-44	32.6%	781,519
45-64	19.7%	472,664
65-74	7.4%	178,675
75+	6.7%	161,571
Total		2,398,721

**Age Composition of African American Washington Women**

<b>Age Group</b>	<b>Percent</b>	<b>Number</b>
<5 Years old	11.4%	9,575
5-19	28.1%	23,604
20-24	8.3%	6,982
25-44	32.8%	27,503
45-64	13.1%	10,952
65-74	3.9%	3,286
75+	2.4%	2,013
Total		83,915

**Age Composition****Native American Washington Women, 1994**

<b>Age Group</b>	<b>Percent</b>	<b>Number</b>
<5 Years Old	10.7%	5,370
5-19	28.8%	14,480
20-24	7.8%	3,943
25-44	32.0%	16,093
45-64	15.7%	7,907
65-74	3.1%	1,574
75+	1.9%	933
Total		50,300

**Age Composition****Asian/Pacific Islander Washington Women, 1994**

<b>Age Group</b>	<b>Percent</b>	<b>Number</b>
<5 Years Old	8.1%	12,531
5-19	24.8%	38,191
20-24	7.8%	11,978
25-44	35%	53,998
45-64	18.2%	28,147
65-74	4.1%	6,374
75+	2.0%	3,070
Total		154,289

### Age Composition of Hispanic Washington Women, 1994

Age Group	Percent	Number
<5 Years Old	14.0%	14,002
<b>5-19</b>	<b>32.0%</b>	<b>32,002</b>
20-24	9.6%	9,651
25-44	31.2%	31,174
45-64	9.8%	9,856
65-74	2.1%	2,145
75+	1.2%	1,244
Total		100,074

### Place of Birth of Washington Women, 1990

Washington Birthplace	48.2%
Northeast Birthplace	3.9%
Midwest Birthplace	13.5%
Southern Birthplace	6.9%
West Birthplace	19.5%
Other U.S. Born	1.5%
Foreign Born	6.6%

### Residence in 1985

#### Washington Women Ages 5 and Older, 1990

Same House in 1985	45.9%
Same County	28.4%
Same State	9.6%
Different State/Other U.S.	13.9%
Foreign Country	2.2%

### Urban or Rural Residence, Washington Women and Men, 1990 (report Figure 3)

	Women	Men
Rural	23.0%	24.2%
Outside Urbanized Area	10.4%	10.3%
Inside Urbanized Area	66.6%	65.5%

### Residence of Washington Women, by Age, 1990

	Rural	Urban
75+ Years	4.8%	<b>6.5%</b>
65-74 Years	7.8%	<b>7.4%</b>
45-64 Years	20.3%	<b>17.5%</b>
25-44 years	32.6%	<b>34.1%</b>
15-24 years	10.9%	<b>13.9%</b>
5-14 Years	16.5%	<b>13.3%</b>
<5 years	7.2%	<b>7.2%</b>

**Marital Status of Washington Women and Men, Ages 16+, 1990**  
(report Figure 4)

	<b>Women</b>	<b>Men</b>
Divorced	11.6%	9.1%
Widowed	10.0%	2.0%
Other	1.5%	2.0%
Separated	2.0%	1.6%
Married, Spouse Present	54.5%	57%
Never Married	20.5%	28.3%

**Washington Women Ever Married, by Age, 1990**

45+ Years	97.1%
35-44 Years	92.0%
25-34 Years	79.1%
15-24 Years	22.5%

**Washington Household Composition, 1990**  
(report Figure 5)

Married, with Children	26.2%
Married, without Children	29.8%
Male-headed, with Children	1.6%
Male-headed, without Children	1.4%
Female-headed, with Children	5.9%
Female-headed, without Children	3.1%
Non-family Households	32.0%

**Female-headed Families with Children <18**  
**By Race, Washington 1990**

Total	5.9%
White	5.3%
African American	16.1%
Native American	15.9%
Asian/Pacific Islander	6.8%
Other	11.3%
Hispanic	10.5%

**Washington Unmarried Partner Households**  
**By Type of Place, 1990**

State	4.6%
Urban Total	4.8%
Inside Urbanized Area	5.0%
Outside Urbanized Area	4.1%
Rural	3.9%

**Gender Composition of Unmarried Partner Households**  
**Washington, 1990**

Both Male	2.7%
Male and Female	95%
Both Female	2.3%

**Unmarried Partner Households By Race  
Washington, 1990**

Hispanic, any Race	6.7%
Other	5.8%
Asian/Pacific Islander	3.5%
Native American	10.4%
African American	6.0%
White	4.5%
Total	4.6%

**Educational Attainment  
Washington Women Ages 25+, 1990**  
(report Figure 6)

	<b>Women</b>	<b>Men</b>
Less than 9th Grade	5.3%	5.7%
9th to 12th Grade (no diploma)	11.2%	10.1%
High School Graduate (includes GED)	29.8%	26.0%
Some College, No Degree	25.7%	24.2%
Associate Degree	8.3%	7.6%
Bachelor's Degree	14.5%	17.4%
Graduate or Professional Degree	5.2%	9.0%

**Educational Attainment by Urban or Rural Residence  
Women Ages 25+, Washington 1990**

	<b>State</b>	<b>Urban</b>	<b>Rural</b>
High School or Greater	83.5%	84.0%	<b>81.6%</b>
Some College	53.7%	55.3%	48.2%
Bachelor's Degree or Greater	19.7%	21.1%	14.9%

**Educational Attainment by Race  
Women Ages 25+, Washington 1990**

	<b>All</b>	<b>White</b>	<b>Nonwhite</b>
High School or Greater	83.5%	84.9%	<b>71.2%</b>
Some College	53.7%	54.4%	<b>46.8%</b>
Bachelor's Degree or Greater	19.7%	20.0%	<b>17%</b>

**Employment Status  
Washington Women and Men Ages 16+, 1990**  
(report Figure 7)

	<b>Women</b>	<b>Men</b>
In Armed Forces	.2%	<b>2.7%</b>
Employed	54.3%	69.0%
Unemployed. Seeking Work	3.3%	4.2%
Not in Paid Labor Force	42.1%	24.2%

**Labor Force Participation by Residence  
Washington Women, 1990**

	<b>Rural</b>	<b>Urban</b>
In Armed Forces	.1%	.3%
Employed	50.2%	55.4%
Unemployed, Seeking Work	3.4%	3.3%
Not in Paid Labor Force	46.3%	41.0%

**Labor Force Participation by Age  
Washington Women, 1990**

	<b>16-19</b>	<b>20-24</b>	<b>25-54</b>	<b>55-64</b>
Employed	47.5%	<b>66.4%</b>	70.4%	<b>41.6%</b>
Unemployed, Seeking Work	7.9%	6.1%	3.5%	<b>1.6%</b>
Not in Paid Labor Force	44.6%	27.5%	26.0%	<b>56.8%</b>

**Hours Worked**

**Employed Washington Women and Men, Ages 16+, 1989**

<b>Hours Worked</b>	<b>Women</b>	<b>Men</b>
35+ Hours/Week	42.7%	<b>69.9%</b>
15-34 Hours/Week	17.7%	<b>9.1%</b>
1-14 Hours/Week	4.2%	<b>2.3%</b>
Not in Paid Labor Force	35.4%	<b>18.7%</b>

**Maternal Labor Force Status by Children's Age  
Washington, 1990**

	<b>Children Younger Than 6</b>	<b>Children Ages 6 to 17</b>
Employed or in Armed Forces	53.7%	72.4%
Unemployed, Seeking Work	4.6%	<b>3.7%</b>
Not in Labor Force	41.7%	<b>23.9%</b>

**Washington Parental Work Status  
By Children's Living Arrangements and Age, 1990**

	<b>Children Younger Than 6</b>	<b>Children Ages 6 to 17</b>
Married Couple, Both Parents Employed	41.4%	<b>50.8%</b>
Married Couple, Father Only Employed	34.5%	<b>23.4%</b>
Married Couple, Mother Only Employed	1.3%	<b>1.9%</b>
Married Couple, Neither Parent Employed	1.7%	<b>1.7%</b>
Male-headed, Employed	3.8%	<b>3.9%</b>
Male-headed, Unemployed	.5%	.5%
Female-headed, Employed	8.8%	<b>13.3%</b>
Female-headed, Unemployed	8.0%	<b>4.6%</b>

**Occupations of Employed Women and Men Ages 16+  
Washington, 1990**

(report Figure 8)

	<b>Women</b>	<b>Men</b>
Managerial, Professional	29.1%	<b>26.6%</b>
Technical, Sales, Administration	43.3%	<b>21.5%</b>
Service	17.3%	9.1%
Farming, Forestry, Fishing	1.4%	5.0%
Precision Production, Crafts, Repairs	2.4%	19.1%
Operators, Fabricators, Laborers	6.5%	18.7%

**Occupation of Employed Women Ages 16+  
By Race, Washington, 1990**

	<b>White</b>	<b>African American</b>	<b>Native American</b>	<b>Asian/ Pacific Islander</b>	<b>Hispanic</b>
Managerial, Professional	30.0%	25.1%	22.5%	23.1%	18.7%
Technical, Sales, Administration	44.0%	44.0%	40.0%	37.1%	34.6%
Service	16.8%	20.5%	24.5%	21.3%	21.7%
Farming, Forestry, Fishing	1.2%	.4%	1.6%	.8%	8.1%
Precision Production, Crafts, Repairs	2.2%	2.9%	2.7%	5.0%	2.6%
Operators, Fabricators, Laborers	5.9%	7.2%	8.8%	12.7%	14.2%

**Industrial Sector Where Employed  
Washington Women and Men Ages 16+, 1990**

	<b>Women</b>	<b>Men</b>
Agriculture, Forestry, Fisheries	2.0%	<b>5.1%</b>
Mining and Construction	1.7%	<b>10.4%</b>
Manufacturing	10.5%	<b>23.2%</b>
Transportation, Communication, Other Utilities	5.2%	<b>9.1%</b>
Wholesale and Retail Trade	23.5%	20.5%
Professional and Related Services	38.9%	18.9%
Other Services	18.3%	12.8%

**Military Status of Women and Men Ages 16 to 64  
Washington, 1990**

	<b>Women</b>	<b>Men</b>
In Armed Forces	0.3%	<b>3.1%</b>
Civilian, Veteran	1.7%	<b>30.1%</b>
Civilian, Nonveteran	98.0%	<b>66.8%</b>

**Median Income by Gender and Residence****Washington Year-long, Full-time Workers, 1989**

	<b>All</b>	<b>Urban</b>	<b>Rural</b>
Women	\$20,607	\$20,871	<b>\$19,235</b>
Men	\$31,026	\$31,110	<b>\$30,753</b>

**Median Income by Gender and Race****Washington Year-long, Full-time Workers, 1989**

(report Figure 9)

	<b>Women</b>	<b>Men</b>
White	\$20,805	<b>\$31,563</b>
African American	\$19,735	<b>\$22,389</b>
Native American	\$18,035	<b>\$23,980</b>
Asian/Pacific Islander	\$19,774	<b>\$27,169</b>
Hispanic	\$16,883	<b>\$20,676</b>

**Family Income by Household Type and Residence****Washington, 1989**

	<b>All</b>	<b>Rural</b>	<b>Urban</b>
Married Couple w/Children <18	\$41,389	\$38,730	\$42,283
Married Couple, No Children	\$36,080	\$33,436	\$36,730
Female-headed w/ Children < 18	\$13,077	\$12,004	\$13,383
Female-headed, No Children	\$7,648	\$6,852	\$7,776

**Income Distribution, Female-headed Families by Race****Washington, 1989**

	<b>&lt;\$15,000</b>	<b>\$15,000- \$24,999</b>	<b>\$25,000- \$49,999</b>	<b>&gt;\$50,000</b>
White	40.6%	23.6%	28.8%	6.9%
African American	55.0%	19.9%	20.7%	4.5%
Native American	64.1%	20.6%	12.5%	2.8%
Asian/Pacific Islander	49.3%	19.8%	22.5%	8.4%
Hispanic	65.3%	18.0%	15.2%	1.6%

**Poverty by Age and Household Type****Washington, 1989**

	<b>&lt;65 Years Old</b>	<b>65 and Older</b>
In Married-couple Family	5.0%	3.2%
Male Household, No Wife Present	14.7%	6.0%
Female Householder, No Husband Present	34.3%	7.6%
Unrelated Individuals in Family Household	41.5%	38.5%
In Nonfamily Households	20.0%	19.8%

**Poverty by Gender and Age**  
**Washington, 1989**  
**(report Figure 10)**

	<b>Women</b>	<b>Men</b>
<6 years	<b>17.1%</b>	<b>16.7%</b>
6-11 years	<b>14.3%</b>	<b>14.2%</b>
<b>12-17 years</b>	<b>12.5%</b>	<b>11.8%</b>
<b>18-64 years</b>	<b>11.3%</b>	<b>8.2%</b>
<b>65-74 years</b>	<b>8.8%</b>	<b>4.8%</b>
>75 years	<b>15.8%</b>	<b>6.9%</b>

**Household Characteristics of Families in Poverty**  
**Washington, 1990**

	<b>Married Couples</b>	<b>Female-headed Households</b>
With Social Security Income in 1989	16.9%	7%
With Public Assistance in 1989	23.1%	54.3%
Householder 65+ Years	13.5%	3.1%
Householders High School Graduate or Higher	64.5%	67.4%
Householder Worked Year Round, Full Time in 1989	17.1%	4.5%
Householder Worked in 1989	60.5%	48.7%

**Poverty by Family Type and Presence of Children**  
**Washington, 1989**  
**(report Figure 11)**

	<b>Married Couples</b>	<b>Male-headed</b>	<b>Female-headed</b>
Children <5 Only	5.7%	21.2%	54.4%
Children 5-17 Only	3.9%	13.1%	29.3%
No Related Children Younger than 18	2.6%	7.1%	7.2%

## Chapter 2

### Health Status and Lifestyle Choices

**Mean Days of Poor Health**  
**Washington Men and Women, 1994**  
**(report Figure 12)**

	<b>Rates</b>		<b>95% CI</b>	
	<b>Men</b>	<b>Women</b>	<b>Men</b>	<b>Women</b>
Mean Days of Poor Physical Health	2.4	3.4	2.0, 2.7	3.1, 3.8
Mean Days of Poor Mental Health, Last 30 Days	2.6	4	2.2, 3.2	3.6, 4.3
Mean Days of Limited Activity, Last 30 Days	1.4	1.8	1.2, 1.7	1.6, 2



## Smoking

### Washington Men and Women Age 18+, 1994

(report Figure 13)

	Rates		Cases		95% CI	
	Men	Women	Men	Women	Men	Women
Ever smoked 100+ Cigarettes	56.9%	44.8%	841	840	54.2, 59.7	42.4, 47.3
Currently Smoking	24.0%	19.0%	358	364	21.9, 26.6	17.6, 21.4

### Activity of Washington Men and Women Age 18+, 1994

(report Figure 14)

	Rates		Cases		95% CI	
	Men	Women	Men	Women	Men	Women
Frequency No Leisure-time Physical Activity	17.0%	20.0%	244	370	14.5, 18.6	17.8, 21.7
Regular and Sustained Activity	25.0%	26.0%	375	486	23.0, 27.8	23.8, 28.1
Regular and Vigorous Activity	15.0%	19.0%	215	357	12.7, 16.5	17.1, 21.0
Sedentary Lifestyle	49.0%	46.0%	725	861	46.4, 51.9	43.5, 48.4

## Diet and Weight Control

### Washington Men and Women Age 18+, 1994

(report Figure 15)

	Rates		Cases		95% CI	
	Men	Women	Men	Women	Men	Women
Behavior Eat $\geq 5$ Servings of Fruits & Vegetables/day	18.0%	25.0%	262	466	15.7, 19.9	22.7, 27
Use Exercise or <Calories to Lose Weight	37.0%	46.0%	152	211	32.1, 42.3	41.5, 51.5

## Prevalence of Overweight

### Washington State Men and Women Ages 18+, 1994

(report Figure 16)

Measure	Rates		Cases		95% CI	
	Men	Women	Men	Women	Men	Females
> 119% of Ideal weight	31.5%	29.0%	466	253	29.0, 34.1	26.8, 31.2
Body Mass Index	26.7%	23.8%	394	447	24.3, 29.1	21.7, 25.9

### Trying to Lose Weight

#### Washington State Women Ages 18+, by Age 1994

(report Figure 17)

	18-24	25-34	35-44	45-54	55-64	65+
Rates	40.0%	42.0%	46.0%	50.0%	49.0%	35.0%
Cases	77	150	219	146	94	117

### AIDS-related Measures

#### Washington Men and Women Age 18-64, 1994

(report Figure 18)

	Rates		Cases		95% CI	
	Men	Women	Men	Women	Men	Women
Ever Had an AIDS Blood Test	42.8%	36.2%	542	551	39.8, 45.8	33.6, 38.9
Have Medium to High Chance of Getting AIDS Virus	8.0%	5.0%	96	69	5.9, 9.3	3.3, 5.7
Increased Risk of Getting AIDS Virus in Past Year	7.0%	5.0%	95	82	5.9, 9.0	4.2, 6.5

## Chapter 3 Health Care Access

### Health Care Access

#### Washington Men and Women Ages 18+, 1994

(report Figure 19)

Measure	Rates		Cases		95% CI	
	Men	Women	Men	Women	Men	Women
Have No Health Care Plan	13.0%	10.0%	186	195	10.7, 14.5	8.9, 11.9
Unable to See a Doctor Due to Cost	10.0%	12.0%	145	232	8.1, 10.6	10.6, 13.9

### Have a Usual Source of Care

#### Washington Men & Women Ages 18+, 1994

(report Figure 20)

Measure	Rates		Cases		95% CI	
	Men	Women	Men	Women	Men	Women
Have a Usual Source of Care	78.1%	90.2%	1,154	1,690	75.8, 80.4	88.7, 91.7

### How Long Since Last Routine Checkup

#### Washington Men & Women, Ages 18+, 1994

(report Figure 21)

	Rates		Cases		95% CI	
	Men	Women	Men	Women	Men	Women
<1 Year	59%	76%	866	1,408	56.1, 61.5	73.7, 77.9
1-2 Years	16%	12%	234	226	14.0, 18.1	10.3, 13.4
2-5 Years	11%	6%	164	104	9.1, 12.4	4.5, 6.9
>5 Years	12%	5%	175	100	9.9, 13.3	4.0, 6.1

**Had a Mammogram and Breast Exam in Last 2 Years  
By Age, Washington Women Age 50+, 1994**

(report Figure 22)

	<b>Rates</b>	<b>Cases</b>	<b>95% CI</b>
All	69.0%	459	65.2, 72.7
Age 50-59	79.0%	192	
Age 60-69	69.0%	129	
Age 70+	59.0%	138	

**Had a Mammogram and Breast Exam in Last 2 Years  
By income, Washington Women Ages 50+, 1994**

(report Figure 23)

<b>Household Income</b>	<b>Percent</b>	<b>Cases</b>
<\$15,000	50.0%	88
\$15-25,000	63.0%	84
\$25-34,999	76.0%	71
\$35-49,999	86.0%	71
\$50,000+	90.0%	73

**Had a Mammogram & Breast Exam in Last 2 Years  
By Education, Washington Women, Ages 50+, 1994**

<b>Education Level</b>	<b>Percent</b>	<b>Cases</b>
< High School	59.0%	53
High School Grad or GED	63.0%	144
Some College/ Technical School	76.0%	165
College Graduate	76.0%	97

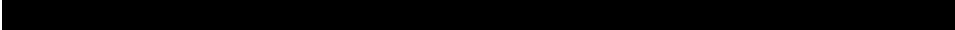
**Had a Pap Smear in Last 3 Years  
Washington State Women with Intact Uteri, by Age, 1994**

(report Figure 24)

<b>Age Group</b>	<b>Percent</b>	<b>Cases</b>	<b>95% CI</b>
All	87.2%	1,276	85.3, 89.1
18-24	85.0%	168	
25-34	93.0%	355	
35-49	87.0%	519	
50-64	87.0%	188	
65+	76.0%	174	

**Had a Pap Smear in Last 3 Years  
Washington State Women With Intact Uterus, by Race, 1994**

<b>Race/Ethnicity</b>	<b>Percent</b>	<b>Cases</b>	<b>95% CI</b>
White	87.3%	1,131	85.3, 89.3
Non-white	85.8%	138	



**Had a Pap Smear in Last 3 Years  
Washington State Women with Intact Uteri, by Income, 1994**

(report Figure 25)

Household Income	Percent	Cases
< \$10,000	<b>79. 0%</b>	<b>121</b>
<b>\$10- \$14, 999</b>	<b>75. 0%</b>	<b>91</b>
<b>\$15- \$19, 999</b>	<b>86. 0%</b>	<b>109</b>
\$20-24,999	<b>87. 0%</b>	<b>129</b>
<b>\$2534, 999</b>	<b>89. 0%</b>	<b>217</b>
<b>\$3549, 999</b>	<b>93. 0%</b>	<b>242</b>
\$50-75,000	<b>92. 0%</b>	<b>157</b>
>\$75,000	<b>94. 0%</b>	<b>96</b>

**Had a Pap Smear in Last 3 Years,  
Washington State Women with Intact Uteri, by Education, 1994**

Educational Attainment	Percent	Cases
< High School	74.0%	81
High School Graduate or GED	86.0%	352
Some College/		
Technical School	87.0%	439
College Graduate	92.0%	395

**Care for Diabetes**

**Washington State Men &Women, Ages 18+, 1994**

Measure	Rates		Cases		95% CI	
	Men	Women	Men	Women	Men	Women
Mean Number of Visits in Past 12 Months	4.4	3.4	62	71	3.1, 5.8	2.3, 4.5

**Was Latest Birth Intended? Washington, 1993**

(report Figure 26)

Intention	Non-Medicaid	Medicaid
Intended Now	50.0%	24.0%
Intended but Sooner Than Wanted	18.0%	15.0%
Unintended but Wanted Later	28.0%	<b>49. 0%</b>
Unintended, Wanted No More Children	4.0%	<b>12. 0%</b>

# **Race-specific Abortion Rates, Washington, 1990 to 1994**

Year	Rate	White		Rate	African American	
		-95%CI	+95%CI		-95%CI	+95%CI
1990	17.9	17.6	18.1	52.8	50.5	55.2
1991	17.3	17.0	17.5	44.5	42.4	46.7
1992	15.6	15.4	15.8	42.8	40.8	4.05
1993	15.8	15.5	16.0	40.4	38.5	42.5
1994	13.1	12.9	13.3	29.7	28	31.4

Year	Rate	Native American		Rate	Asian/Pacific Islander	
		-95%CI	+95%CI		-95%CI	+95%CI
1990	19.3	17.6	21.3	28.7	27.4	30.1
1991	18.4	16.7	20.3	20.3	19.2	21.4
1992	12.0	10.7	13.5	20.8	19.8	21.9
1993	12.7	11.3	14.2	21.0	20.0	22.0
1994	7.7	6.6	8.9	18.4	17.5	19.4

Year	Rate	Hispanic	
		-95%CI	+95%CI
1990	0.0	0.0	0.0
1991	10.1	9.3	11.0
1992	8.7	8.0	9.5
1993	9.6	8.8	10.4
1994	7.3	6.7	8.0

## **Abortion Rates, 15-44 Year-olds Washington, 1980 to 1995 (report Figure 27)**

Year	Abortions	Population	Year	Total
1980	31,095	982,660	1980	31.6
1981	31,694	1,012,120	1981	31.3
1982	30,047	1,024,704	1982	29.3
1983	28,572	1,029,732	1983	27.7
1984	28,651	1,042,867	1984	27.5
1985	27,493	1,061,003	1985	25.9
1986	28,729	1,073,620	1986	26.8
1987	31,041	1,087,409	1987	28.5
1988	30,924	1,103,522	1988	28.0
1989	32,197	1,123,340	1989	28.7
1990	32,219	1,151,604	1990	28.0
1991	31,667	1,178,730	1991	26.9
1992	28,916	1,192,605	1992	24.2
1993	28,904	1,209,841	1993	23.9
1994	27,400	1,221,299	1994	22.4
1995	25,335	1,221,009	1995	20.7

**Abortion Rates, 15-17 Year-olds  
Washington, 1980 to 1995**

(report Figure 28)

<b>Year</b>	<b>Abortions</b>	<b>Population</b>	<b>Year</b>	<b>Total</b>
1980	4,065	104,933	1980	38.7
1981	3,719	101,440	1981	36.7
1982	3,323	96,954	1982	34.3
1983	3,038	93,750	1983	32.4
1984	3,005	94,258	1984	31.9
1985	2,945	97,145	1985	30.3
1986	3,103	100,209	1986	31.0
1987	3,190	98,318	1987	32.4
1988	2,980	94,482	1988	31.5
1989	2,837	89,254	1989	31.8
1990	2,655	90,090	1990	29.5
1991	2,503	91,569	1991	27.3
1992	2,436	94,969	1992	25.7
1993	2,527	98,787	1993	25.6
1994	2,461	102,665	1994	24.0
1995	2,261	108,293	1995	20.9

**First Trimester Care, Washington, 1980 to 1995**

(report Figure 29)

<b>Year</b>	<b>Total</b>	<b>White</b>	<b>African Amer.</b>	<b>Native Amer.</b>	<b>Asian/Pacific Islander</b>	<b>Hisp.</b>
1980	79.5%	81.7%	66.6%	59.7%	70.1%	52.0%
1981	79.1%	81.3%	67.4%	58.6%	68.1%	55.0%
1982	77.7%	79.9%	63.3%	57.9%	66.7%	55.9%
1983	77.7%	79.9%	63.5%	57.1%	66.9%	55.6%
1984	78.2%	80.2%	64.4%	61.7%	69.9%	59.0%
1985	77.9%	79.9%	64.4%	58.0%	69.3%	58.8%
1986	77.5%	79.4%	63.7%	60.7%	69.5%	60.3%
1987	77.2%	79.3%	61.2%	60.0%	67.5%	60.8%
1988	77.1%	79.6%	61.9%	55.8%	69.1%	58.1%
1989	77.0%	80.2%	60.8%	57.9%	69.6%	56.5%
1990	77.9%	80.6%	64.6%	61.1%	71.9%	56.7%
1991	79.0%	82.7%	66.4%	60.9%	72.4%	54.9%
1992	79.8%	83.4%	68.9%	65.3%	73.6%	57.8%
1993	80.7%	84.2%	70.3%	66.5%	76.0%	61.1%
1994	82.5%	85.5%	75.5%	70.5%	78.3%	65.8%
1995	82.6%	85.6%	75.8%	70.3%	77.8%	68%

**Late or No Prenatal Care, Washington, 1980 to 1995**



(report Figure 30)

Year	Total	White	African Amer.	Native Amer.	Asian/Pacific Islander	Hisp.
1980	3.8%	2.8%	6.9%	9.8%	6.5%	17.5%
1981	3.9%	3.1%	6.5%	11.5%	8.2%	15.0%
1982	4.5%	3.6%	7.5%	13.8%	7.8%	15.6%
1983	4.5%	3.7%	9.0%	12.5%	7.6%	16.7%
1984	4.9%	4.1%	9.9%	11.6%	7.2%	14.0%
1985	4.6%	3.9%	9.9%	11.8%	7.1%	12.2%
1986	4.9%	4.0%	12%	12.3%	6.8%	12.5%
1987	4.9%	4.1%	10.9%	11.5%	7.8%	11.9%
1988	4.9%	4.0%	11.3%	13.9%	6.4%	12.6%
1989	5.3%	4.0%	11.7%	13.7%	6.8%	13.8%
1990	4.4%	3.4%	8.2%	10.7%	6.2%	12.2%
1991	4.1%	2.9%	7.3%	11.0%	6.3%	11.9%
1992	4.0%	2.8%	7.9%	9.6%	5.1%	11.3%
1993	3.7%	2.7%	7.7%	8.6%	4.7%	9.2%
1994	3.4%	2.5%	6.1%	7.1%	4.7%	7.5%
1995	3.5%	2.7%	6.3%	7.9%	5.1%	6.7%

## Chapter 4 Health Status Indicators

### Petitions Filed for Domestic Violence and Civil Anti-harrassment Protection Orders, Washington, 1992 to 1993

Year	Cases	Population	Rate	Lower Bound	Upper Bound
1992	26,646	5,116,721	5.2	5.1	5.3
1993	29,282	5,240,926	5.6	5.5	5.7
Period	55,928	10,357,647	5.4	5.4	5.4

### Arrests of Adults for Domestic Violence-related Events

#### Washington, 1988 to 1993

(report Figure 31)

(rates per 1,000)

Year	Cases	Population	Rate	Lower Bound	Upper Bound
1988	10,631	3,414,825	3.1	3.1	3.2
1989	13,309	3,494,279	3.8	3.7	3.9
1990	15,541	3,594,310	4.3	4.3	4.4
1991	15,878	3,690,338	4.3	4.2	4.4
1992	19,378	3,769,246	5.1	5.1	5.2
1993	20,524	3,854,053	5.3	5.3	5.4
Period			4.4	4.3	4.4

**Proportion of Selected Crimes That Are Domestic Violence**  
(report Figure 32)

**July-December 1995**

<b>Crime</b>	<b>Percent</b>	<b>All</b>	<b>Domestic Violence-related</b>
Criminal Homicide	26.8%	164	44
Assault	43.4%	44,188	19,175
Forcible rape	6.7%	1,559	104
Robbery	1.3%	3,636	47
Burglary	1.1%	29,466	330

**Acute PID Washington State Women, 1991 to 1995**  
(report Figure 33)

(rates per 100,000)

	<b>Rates</b>	<b>Cases</b>	<b>-95%CI</b>
1991	38.4	969	36.1, 41
1992	39.2	1,008	36.8, 41.7
1993	29.8	787	<b>27.8, 32</b>
1994	22.9	615	<b>21.1, 24.8</b>
1995	18.2	498	<b>16.7, 19.9</b>

**Gonorrhea**

**Washington State Women and Men, 1991 to 1995**

(report Figure 34)

(rates per 100,000)

<b>Year</b>	<b>Rates</b>		<b>Cases</b>		<b>95% CI</b>	
	<b>Men</b>	<b>Women</b>	<b>Men</b>	<b>Women</b>	<b>Men</b>	<b>Women</b>
1991	89.7	92.8	2,164	2,277	85.9, 93.5	89.1, 96.7
1992	90.5	80.9	2,185	1,984	86.8, 94.4	77.4, 84.5
1993	76.4	66.4	1,986	1,754	73, 79.8	63.4, 69.6
1994	57.5	51.1	1,521	1,372	54.6, 60.4	48.4, 53.8
1995	54.2	47.7	1,464	1,301	51.5, 57.1	45.1, 50.3

**Chlamydia Infections**

**Washington Women and Men, 1991 to 1995**

(report Figure 35)

(rates per 100,000)

<b>Year</b>	<b>Rates</b>		<b>Cases</b>		<b>95% CI</b>	
	<b>Men</b>	<b>Women</b>	<b>Men</b>	<b>Women</b>	<b>Men</b>	<b>Women</b>
1991	110.8	417.5	2,675	10,242	<b>106.7, 115.1</b>	409.5, 425.7
1992	382.5	80.9	2,379	9,383	<b>94.6, 102.6</b>	<b>374.8, 390.3</b>
1993	306.5	66.4	2,238	8,093	<b>82.5, 89.7</b>	<b>299.9, 313.3</b>
1994	314.8	51.1	2,118	8,459	<b>76.6, 83.5</b>	<b>308.1, 321.6</b>
1995	275.1	47.7	1,954	7,508	69.2, 75.6	<b>268.9, 281.4</b>



# Early Syphilis Infections

Washington Women and Men, 1991 to 1995

(report Figure 36)

(rates per 100,000)

Year	Rates	Cases	-95% CI		+95% CI	
	Men	Women	Men	Women	Men	Women
1991	5.8	5.8	139	143	4.8, 6.8	4.9, 6.9
1992	3.5	2.6	84	65	2.8, 4.3	2, 3.4
1993	2.2	2.2	56	57	1.6, 2.8	1.6, 2.8
1994	1.4	1.2	38	33	1, 2	.8, 1.7
1995	.6	.4	17	12	69.2, 75.6	.2, .8

# Births by Race

Washington, 1980 to 1995

Year	Total	White	African Amer.	Native Amer.	Asian/Pacific Islander	Hisp.
1980	67,469	59,806	2,050	1,247	2,486	1,880
1981	69,489	60,869	2,264	1,275	3,077	2,004
1982	69,294	60,572	2,384	1,299	3,125	1,914
1983	68,448	60,144	2,355	1,318	2,875	1,756
1984	68,467	59,943	2,393	1,363	2,955	1,813
1985	69,847	60,994	2,526	1,456	3,091	1,780
1986	69,881	61,019	2,527	1,457	3,094	1,784
1987	69,497	60,284	2,694	1,593	3,164	1,762
1988	71,670	61,063	2,757	1,693	3,474	2,683
1989	73,863	60,896	2,830	1,888	3,812	4,437
1990	77,795	64,218	2,849	1,688	3,830	5,210
1991	78,159	63,381	3,003	1,675	4,119	5,981
1992	77,561	61,885	3,042	1,657	4,423	6,554
1993	76,868	60,313	3,064	1,662	4,757	7,072
1994	75,121	58,301	2,956	1,619	4,843	7,402
1995	74,939	57,613	2,841	1,665	5,042	7,778

Year	White	African Amer.	Native Amer.	Asian/Pacific Islander	Hisp.
1980	88.6%	3%	1.8%	3.7%	2.8%
1981	87.6%	3.3%	1.8%	4.4%	2.9%
1982	87.4%	3.4%	1.9%	4.5%	2.8%
1983	87.9%	3.4%	1.9%	4.2%	2.6%
1984	87.6%	3.5%	2.0%	4.3%	2.6%
1985	87.3%	3.6%	2.1%	4.4%	2.5%
1986	87.3%	3.6%	2.1%	4.4%	2.6%
1987	86.7%	3.9%	2.3%	4.6%	2.5%
1988	85.2%	3.8%	2.4%	4.8%	3.7%
1989	82.4%	3.8%	2.6%	5.2%	6.0%
1990	82.5%	3.7%	2.2%	4.9%	6.7%
1991	81.1%	3.8%	2.1%	5.3%	7.7%
1992	79.8%	3.9%	2.1%	5.7%	8.5%
1993	78.5%	4.0%	2.2%	6.2%	9.2%
1994	77.6%	3.9%	2.2%	6.4%	9.9%
1995	76.9%	3.8%	2.2%	6.7%	10.4%

# **Average Lifetime Births by Race Washington, 1980 to 95**

(report Figure 37)

Year	Total	White	African Amer.	Native Amer.	Asian/Pacific Islander	Hisp.
1980	1.8					
1981	.8					
1982	1.8					
1983	.8					
1984	.8					
1985	.9					
1986	.9					
1987	1.9					
1988	1.9					
1989	2.0					
1990	2.1	1.9	2.2	2.2	1.9	2.8
1991	2.1	1.8	2.3	2.1	1.8	3
1992	2	1.8	2.2	2.1	1.9	3.1
1993	2	1.7	2.2	2	1.9	3.2
1994	2	1.7	2.1	1.9	1.9	3.2
1995	2					

# **Pregnancy Rates, 15-17 Year-olds Washington, 1980 to 1995**

(report Figure 38)

Events				Rates				
Year	Births	Abor- tions	Preg- nancies	Pop.	Year	Births	Abor- tions	Preg- nancies
1980	2, 605	4, 065	6, 670	104, 933	980	24.8	38. 7	63.6
1981	2, 603	3, 719	6, 322	101,440	981	25.7	36. 7	62.3
1982	2, 392	3, 323	5, 715	96,954	982	24.7	34. 3	58.9
1983	2, 254	3, 038	5, 292	93,750	1983	24.0	32. 4	56.4
1984	2, 181	3, 005	5, 186	94,258	1984	23.1	31. 9	55.0
1985	2, 394	2, 945	5, 339	97,145	985	24.6	30. 3	55.0
1986	2, 421	3, 103	5, 524	100,209	986	24.2	31. 0	55.1
1987	2, 476	3, 190	5, 666	98,318	987	25.2	32. 4	57.6
1988	2, 505	2, 980	5, 485	94,482	988	26.5	31. 5	58.1
1989	2, 562	2, 837	5, 399	89,254	989	28.7	31. 8	60.5
1990	2, 682	2, 655	5, 337	90,090	990	29.8	29. 5	59.2
1991	2,838	2,503	5,341	91,569	1991	31.0	27. 3	58.3
1992	3,124	2,436	5,560	94,969	1992	32.9	25. 7	58.5
1993	3,048	2,527	5,575	98,787	1993	30.9	25. 6	56.4
1994	3,042	2,46 1	5,503	102,665	1994	29.6	24. 0	53.6
1995	3,121	2,26 1	5,382	108,293	1995	28.8	20. 9	49.7

### Proportion of Births to Mothers age <18, Washington, 1980 to 1995

(report Figure 39)

Year	Total		White	African Amer.	Native Amer.	Asian/Pacific Islander	Hisp.
1980	4.0%	3.6%	9.8%	10.4%	1.2%	8.2%	
1981		3.8%	3.4%	7.2%	10.6%	1.8%	9.6%
1982		3.6%	3.2%	7.6%	9.2%	2.2%	8.3%
1983		3.4%	3.0%	6.8%	11.2%	1.9%	7.7%
1984		3.3%	2.9%	7.9%	9.6%	2.1%	8.4%
1985		3.6%	3.2%	8.2%	8.4%	2.4%	7.9%
1986		3.7%	3.2%	7.6%	11.2%	2.2%	9.3%
1987		3.7%	3.2%	8.6%	9.9%	2.2%	9.8%
1988		3.6%	3.0%	8.5%	9.8%	2.1%	8.7%
1989		3.5%	2.9%	8.3%	9.4%	2.5%	7.6%
1990		3.5%	2.9%	8.1%	8.6%	2.5%	7.9%
1991		3.7%	3.0%	8.5%	9.9%	1.9%	8.1%
1992		4.1%	3.3%	8.3%	10.6%	2.7%	8.5%
1993		4.1%	3.3%	8.1%	9.7%	2.6%	8.1%
1994		4.2%	3.4%	8.2%	10.6%	2.5%	8.0%
1995		4.3%	3.5%	8.8%	9.8%	3.1%	8.1%

### Proportion of Births to Single Mothers, Washington, 1980 to 1995

(report Figure 40)

Year	Total	White	African Amer.	Native Amer.	Asian/Pacific Islander	Hisp.
1980	13.6%	12%	46.3%	47.9%	4.6%	18.9%
1981	14.5%	12.8%	45.1%	50.5%	6.2%	20.5%
1982	14.5%	12.5%	44.8%	49.9%	8.4%	26.1%
1983	15.8%	13.8%	43.9%	56.2%	10.5%	23.7%
1984	16.8%	14.8%	47.0%	53.8%	11.5%	25.7%
1985	18.4%	16.2%	50.1%	55.7%	13.7%	28.2%
1986	19.8%	17.4%	49.8%	58.5%	15.3%	31.3%
1987	20.7%	18.2%	52.1%	59.9%	16.6%	32.5%
1988	22.3%	19.7%	53.1%	60.7%	17.9%	31.8%
1989	23.4%	20.4%	54.2%	59.9%	19.2%	33.0%
1990	23.7%	20.9%	54.7%	62.5%	17.2%	33.7%
1991	24.9%	22.0%	54.8%	62.6%	18.4%	34.8%
1992	25.4%	22.2%	55.8%	61.4%	19.9%	35.4%
1993	26.3%	23.1%	56.1%	60.5%	20.8%	36.5%
1994	26.1%	23%	55.6%	57.8%	20.3%	35.9%
1995	26.9%	23.6%	55.7%	60.9%	19.9%	38.0%

### Percent of Mothers with More than a High School Education

Washington, 1992 to 1995

(report Figure 41)

Year	Total	White	African Amer.	Native Amer.	Asian/Pacific Islander	Hisp.
1992	45.3%	48.4%	38.9%	22.7%	52.6%	14.4%
1993	47.1%	51.0%	39.7%	27.2%	54.1%	13.8%
1994	48.1%	52.6%	41.3%	28.1%	54.9%	13.1%
1995	48.8%	53.8%	40.9%	25.1%	54.3%	13.4%

**Percent of Mothers Who Smoked While Pregnant  
Washington, 1984 to 1995**

(report Figure 42)

<b>Year</b>	<b>Total</b>	<b>White</b>	<b>African Amer.</b>	<b>Native Amer.</b>	<b>Asian/Pacific Islander</b>	<b>Hisp.</b>
1984	22.9%	23.7%	24.7%	<b>35.3%</b>	<b>8.8%</b>	<b>7.8%</b>
1985	25.6%	26.3%	30.3%	40.0%	<b>9.5%</b>	9.1%
1986	25.3%	26.0%	28.9%	41.2%	<b>9.1%</b>	9.4%
1987	25.1%	25.8%	28.3%	42.0%	<b>9.5%</b>	7.6%
1988	25.0%	26.0%	29.8%	39.4%	<b>8.9%</b>	8.5%
1989	21.8%	23.2%	23.9%	35.1%	<b>8.2%</b>	7.6%
1990	20.0%	21.8%	18.1%	34.7%	<b>6.5%</b>	3.9%
1991	19.4%	21.2%	19.0%	32.6%	<b>5.8%</b>	5.2%
1992	20.1%	22.1%	22.3%	32.6%	<b>6.3%</b>	6.3%
1993	18.0%	20.1%	18.9%	31.3%	<b>6.9%</b>	4.4%
1994	17.1%	19.2%	17.1%	31.0%	<b>6.7%</b>	45.1%
1995	16.2%	18.4%	15.9%	30.4%	<b>5.5%</b>	3.7%

**Proportion of Low Birthweight Infants  
Washington, 1980 to 1982 through 1992 to 1994**

(report Figure 43)

<b>Period</b>	<b>Total</b>	<b>-95% CI</b>	<b>+95%CI</b>	<b>White</b>	<b>-95%CI</b>	<b>+95%CI</b>
1980-82	<b>5.1%</b>	<b>5.0%</b>	5.2%	<b>4.8%</b>	<b>4.7%</b>	4.9%
1983-85	<b>5.2%</b>	<b>5.1%</b>	5.3%	<b>4.9%</b>	<b>4.8%</b>	5.0%
<b>1986-88</b>	<b>5.3%</b>	<b>5.2%</b>	5.4%	<b>4.8%</b>	<b>4.7%</b>	5.0%
<b>1989-91</b>	<b>5.4%</b>	<b>5.3%</b>	5.4%	<b>5.0%</b>	<b>4.9%</b>	5.1%
<b>1992-94</b>	<b>5.2%</b>	<b>5.1%</b>	5.3%	<b>4.9%</b>	<b>4.8%</b>	5.0%

<b>Period</b>	<b>African American</b>	<b>-95% CI</b>	<b>+95%CI</b>	<b>Native American</b>	<b>-95% CI</b>	<b>+95% CI</b>
1980-82	11.5%	10.7%	12.4%	<b>6.1%</b>	5.4%	7%
1983-85	11.3%	10.6%	12.1%	<b>6.4%</b>	5.7%	7.3%
1986-88	12.0%	11.2%	12.7%	<b>7.4%</b>	6.6%	8.2%
1989-91	11.9%	11.2%	12.7%	<b>6.1%</b>	5.5%	6.9%
1992-94	11.1%	10.4%	11.8%	<b>5.6%</b>	4.9%	6.3%

<b>Period</b>	<b>Asian/ Pacific Islander</b>	<b>-95% CI</b>	<b>+95%CI</b>	<b>Hispanic</b>	<b>-95% CI</b>	<b>+95% CI</b>
1980-82	6.4%	5.9%	7.0%	5.4%	4.8%	6.0%
1983-85	5.9%	5.4%	6.5%	5.8%	5.1%	6.4%
1986-88	6.3%	5.8%	6.9%	5.0%	4.5%	5.6%
1989-91	6.6%	6.1%	6.1%	5.0%	4.7%	5.4%
1992-94	5.7%	5.3%	5.3%	5.1%	4.8%	5.4%

# **Infant Mortality Rates, Washington, 1980 to 1982 through 1992 to 1994**

(report Figure 44)

(deaths per 1,000 births)

<b>Period</b>	<b>Total</b>	<b>-95%CI</b>	<b>+95%CI</b>	<b>White</b>	<b>-95%CI</b>	<b>+95%CI</b>
1980-82	10.6	10.1	11.0	9.9	9.5	10.4
1983-85	9.7	9.3	10.1	9.3	8.9	9.7
1986-88	9.3	8.9	9.7	8.8	8.3	9.2
1989-91	7.9	7.6	8.3	7.3	7.0	7.7
1992-94	6.1	5.8	6.0	6.0	5.6	6.4

<b>Period</b>	<b>African American</b>	<b>-95%CI</b>	<b>+95%CI</b>	<b>Native American</b>	<b>-95%CI</b>	<b>+95%CI</b>
1980-82	17.9	14.9	21.4	25.6	20.8	31.3
1983-85	18.3	15.3	21.7	16.7	13.0	21.1
1986-88	16.9	14.2	20.0	18.3	14.7	22.6
1989-91	15.9	13.3	18.7	19.8	16.2	24.0
1992-94	11.8	9.7	14.2	9.9	7.3	13.1

<b>Period</b>	<b>Asian/ Pacific Islander</b>	<b>-95%CI</b>	<b>+95%CI</b>	<b>Hispanic</b>	<b>-95%CI</b>	<b>+95%CI</b>
1980-82	10.2	8.2	12.6	12.2	9.6	15.5
1983-85	8.2	6.4	10.3	8.8	6.5	11.7
1986-88	9.0	7.2	11.1	7.6	5.6	10.1
1989-91	6.7	5.2	8.4	7.7	6.4	9.2
1992-94	4.3	3.3	5.5	5.1	4.2	6.2

## **Life Expectancy**

### **Washington Women and Men, 1980 to 1995**

(report Figure 45)

<b>Year</b>	<b>Women</b>	<b>Men</b>
1980	78.0	71.1
1981	78.4	71.6
1982	78.5	72.0
1983	78.8	72.3
1984	78.6	72.1
1985	78.6	72.2
1986	78.9	72.6
1987	78.9	72.7
1988	78.8	72.6
1989	79.1	73.2
1990	79.3	73.2
1991	79.9	73.7
1992	79.7	73.7
1993	79.4	71.3
1994	79.8	73.8
1995	79.7	74.1

**Age-adjusted Death Rates**  
**Female Breast Cancer, 1980 to 1995**

(report Figure 47)  
(deaths per 100,000)

Year	
1980	21.0
1981	21.0
1982	22.5
1983	22.4
1984	23.1
1985	22.3
1986	21.9
1987	21.2
1988	24.3
1989	23.1
1990	21.2
1991	21.7
1992	21.0
1993	21.0
1994	18.9
1995	20.7

**Age-adjusted Death Rates from Cervical Cancer**  
**Washington, 1980 to 1995**

(report Figure 48)  
(deaths per 100,000)

1980	2.7
1981	2.4
1982	2.3
1983	2.6
1984	2.4
1985	2.2
1986	2.1
1987	1.9
1988	2.1
1989	2.2
1990	2.4
1991	2.0
1992	1.6
1993	2.0
1994	2.1
1995	2.3

**Age-adjusted Death Rates from Lung Cancer  
Washington, 1980 to 1995**

**(report Figure 49)**

(deaths per 100,000)

	<b>Men</b>	<b>Women</b>
<b>1980</b>	<b>54.6</b>	<b>21.9</b>
<b>1981</b>	<b>52.6</b>	<b>22.9</b>
<b>1982</b>	<b>51.6</b>	<b>22.5</b>
<b>1983</b>	<b>51.4</b>	<b>22.6</b>
<b>1984</b>	<b>52.1</b>	<b>24.9</b>
<b>1985</b>	<b>54.3</b>	<b>23.8</b>
<b>1986</b>	<b>54.6</b>	<b>25.5</b>
<b>1987</b>	<b>50.9</b>	<b>26.6</b>
<b>1988</b>	<b>50.4</b>	<b>28.1</b>
<b>1989</b>	<b>52.2</b>	<b>27.3</b>
<b>1990</b>	<b>52.5</b>	<b>29.0</b>
<b>1991</b>	<b>50.4</b>	<b>28.7</b>
<b>1992</b>	<b>52.2</b>	<b>29.7</b>
<b>1993</b>	<b>53.1</b>	<b>29.3</b>
<b>1994</b>	<b>47.9</b>	<b>29.7</b>
<b>1995</b>	<b>46.5</b>	<b>30.7</b>

**Age-adjusted Death Rates from COPD, Washington, 1980 to 1995**

**(report Figure 50)**

(deaths per 100,000)

<b>Year</b>	<b>Male</b>	<b>Female</b>
<b>1980</b>	<b>29.1</b>	<b>13.3</b>
<b>1981</b>	<b>32.4</b>	<b>12.5</b>
<b>1982</b>	<b>30.3</b>	<b>13.9</b>
<b>1983</b>	<b>32.0</b>	<b>15.1</b>
<b>1984</b>	<b>30.9</b>	<b>16.3</b>
<b>1985</b>	<b>30.3</b>	<b>17.9</b>
<b>1986</b>	<b>31.4</b>	<b>18.1</b>
<b>1987</b>	<b>29.9</b>	<b>18.3</b>
<b>1988</b>	<b>32.0</b>	<b>18.7</b>
<b>1989</b>	<b>29.3</b>	<b>20.0</b>
<b>1990</b>	<b>29.8</b>	<b>19.7</b>
<b>1991</b>	<b>28.7</b>	<b>19.6</b>
<b>1992</b>	<b>29.3</b>	<b>21.5</b>
<b>1993</b>	<b>30.3</b>	<b>21.8</b>
<b>1994</b>	<b>28.9</b>	<b>21.7</b>
<b>1995</b>	<b>27.5</b>	<b>19.8</b>

**Oral-pharynx Cancer Death Rates, 1980 to 1982 through 1993 to 1995  
Washington Women and Men Ages 45-74**

**(report Figure 51)**

(deaths per 100,000)

<b>Year</b>	<b>Male</b>	<b>Female</b>
<b>1980-82</b>	<b>11.8</b>	<b>6.3</b>
<b>1981-83</b>	<b>12.6</b>	<b>6.0</b>
<b>1982-84</b>	<b>12.6</b>	<b>6.3</b>
<b>1983-85</b>	<b>12.9</b>	<b>6.0</b>
<b>1984-86</b>	<b>11.8</b>	<b>5.8</b>
<b>1985-87</b>	<b>10.8</b>	<b>5.3</b>
<b>1986-88</b>	<b>9.4</b>	<b>4.9</b>
<b>1987-89</b>	<b>10.5</b>	<b>5.4</b>
<b>1988-90</b>	<b>11.3</b>	<b>4.9</b>
<b>1990-92</b>	<b>10.8</b>	<b>4.3</b>
<b>1991-93</b>	10.1	4.7
1992-94	9.5	4.8
1993-95	9.3	5.2